SOUTHEASTERN
LOUISIANA UNIVERSITY

ADDENDUM NO. 2, DATED 06/09/20

RE: Invitation to Bid to be Returned June 23, 2020, 4:00 p.m. CST
SECONDARY AGGREGATE or ZERO DEDUCTIBLE INSURANCE (IAI)
FOR STUDENT-ATHLETES and OTHER PARTICIPANTS
FOR THE SOUTHEASTERN ATHLETICS DEPARTMENT

Dear Bidder,

This Addendum is issued to answer the questions posed by the inquiry deadline.

The bidder should acknowledge receipt of the addendum by:
1) Referencing the addendum on the Response Signature form; or
2) by including the addendum with the bid response; or
3) by returning the addendum under separate cover if the response has already been mailed.

Sincerely,

Phyllis Hoover

Phyllis Hoover, CPPB

Name of Bidder:

_____

Acknowledged by:

_____

Signature Date

Purchasing and Property Control Dept. * SLU 10800 * Hammond, LA 70402 * 985-549-2064 *
Fax 985-549-3810
A member of the University of Louisiana System

Secondary Insurance Questions

Information for the Secondary Aggregate Coverage as requested by vendors:

Will the University Consider an ACA exempt group plan for International Student coverage?
No, The university must have an ACA compliant plan due to all international students being required to have this insurance and will not be given the choice of enrollment.

Claims History for the past 5 years – Total paid claims reports with a "paid through" date of at no earlier than 5/1/20 for the following policy years: 2019-2020, 2018-2019, 2017-2018, 2016-2017 and 2015-2016.
See attached

Claims/Losses reported for 2017-2018 are through March 1, 2018.
All losses reported are only for secondary policy.
15-16 All Sports Claims Loss Report - $382,073.61 - Borden Perlman
16-17 All Sports Claims Loss Report - $131,857.50 -Borden Perlman
17-18 All Sports Claims Loss Report - $38,954.39 - Eben Concepts
18-19 All Sports Claim Loss Report - $177,054.30 - Eben Concepts
19-20 All Sports Claim Loss Report - $ 152,394.99 – Eben Concepts

Premium Total Paid Premium for the following Policy years: 2019-2020, 2018-2019, 2017-2018, 2016-2017 and 2015-2016

Secondary Aggregate premiums (premium plus administrative costs plus aggregate deductible)
2015-2016 – Borden Perlman, LLC $65,233 premium/$228,325 aggregate/ $ 0 Administrative Fee
2016-2017 – Borden Perlman, LLC $68,242 premium/$251,100 aggregate/ $ 0 Administrative Fee
2017-2018 – EbenConcepts $47,500 premium/$240,000 aggregate/ $ 0 Administrative Fee
2018-2019 – EbenConcepts $51,000 premium/$240,000 aggregate/ $ 0 Administrative Fee
2019-2020 – EbenConcepts $51,000 premium/$220,000 aggregate/ $ 0 Administrative Fee

Total All Secondary Premiums insurance (premiums only)
15-16 All Secondary insurance premium - $34,250 – Borden Perlman
16-17 All Secondary insurance premium - $34,665 – Borden Perlman
17-18 All Secondary insurance premium - $30,500 – Eben Concepts
18-19 All Secondary insurance premium - $34,000 – Eben Concepts
19-20 All Secondary insurance premium - $34,000 – Eben Concepts

There was no individual enrollment in the secondary policy. All athletes were covered and added to the policy as individual claims were generated. All losses reported are only for the secondary policy.

A list of plan changes, if any, for the following policy years: 2019-2020, 2018-2019, 2017-2018, 2016-2017 and 2015-2016.
ACA compliancy added in 2018-2019 otherwise same

A list of added or deleted sports and their participation numbers for the following policy years: 2019-2020, 2018-2019, 2017-2018, 2016-2017 and 2015-2016

2019-2020: Same as in ITB Document
2018-2019: Same as 2019-2020
2017-2018: Remove Beach Volleyball
2016-2017: Same as 2017-2018
2015-2016: Same as 2016-2017

Outline of the plan design, including aggregate deductible, specific deductible, premium and administration costs for the following policy years: 2019-2020, 2018-2019, 2017-2018, 2016-2017 and 2015-2016
See above

What are the average discount percentages that your claims administrator is currently receiving at your top 3 medical providers? And what percentage of savings fee do you pay on average?

North Oaks Medical Center –
30% savings off of any remaining balance if covered by primary insurance
60% savings off of billed charges for those without primary coverage, Medicaid or primary insurance denials

North Oaks Physician Group –
30% savings off of any remaining balance if covered by primary insurance
40% savings off of billed charges for those without primary coverage, Medicaid or primary insurance denials

Hosp Based Phys-Radiologists –
30% savings off of any remaining balance if covered by primary insurance
60% savings off of billed charges for those without primary coverage, Medicaid or primary insurance denials

No savings fees being paid

Under Section 3.5, Item B - Platelet Rich Plasma (PRP) Therapy is not included as a covered item. Please confirm you do not want aPRP Therapy in an Aggregate Deductible Plan.

We do not want PRP Therapy coverage in an Aggregate plan.

Under Section 3.5, Item B – Please define the individual occurrence and aggregate deductible(s) that would be acceptable to Southeastern Louisiana University.

As a reminder, the NCAA sponsors a catastrophic injury insurance program for any student-athlete that is catastrophically injured while participating in a covered intercollegiate athletic activity. The policy provides benefits in excess of any other valid and collectible insurance. In this instance, the NCAA's catastrophic insurance program is triggered once a student-athlete has medical expenses exceeding $90,000 so we cannot make any changes to the limits we listed.

Claims Paid Report can be obtained in an Excel spreadsheet by e-mailing:

Phyllis Hoover – phoover@selu.edu

Note: No data was returned for 2015

FIDELITY SECURITY LIFE INSURANCE COMPANY

3130 Broadway
Kansas City, Missouri 64111-2406
Phone 800-648-8624
A STOCK COMPANY
(Herein Called "the Company")

The Certificate is issued to Insureds of the Policyholder whose coverage is in effect according to the Company's records.

The Certificate describes the principal provisions of the Policy. Benefits are provided only while coverage is in force for an Insured according to the terms of the Policy. All periods of insurance begin and end at 12:01 a.m. Local Time at the Policyholder's business address.

This Certificate replaces all certificates that may have been previously issued to the Insured under the Policy.

The Policy may be amended, changed, cancelled or discontinued without the consent of any Insured.

The Policy is issued by Fidelity Security Life Insurance Company at Kansas City, Missouri on the Policy Effective Date.

FIDELITY SECURITY LIFE INSURANCE COMPANY

President Secretary

BLANKET SPORTS ACCIDENT INSURANCE CERTIFICATE
SPECIFIED TERM
SICKNESS NOT COVERED
THIS IS A LIMITED BENEFIT CERTIFICATE
Please read the Certificate carefully.

CONTENTS

DEFINITIONS

Accident means an external event occurring by chance or unintentionally during the Policy Term. An Accident must be independent of any Sickness. The Insured must be covered under the Policy and be participating in a Covered Activity related to a Covered Sport at the time of the Accident.

Aircraft means a vehicle which:

1. has a valid Airworthiness Certificate; and
2. is being flown by a pilot with a valid license to operate such vehicle.

Airworthiness Certificate means a "Standard" Airworthiness Certificate issued by the Federal Aviation Agency of the United States of America (FAA) or its equivalent issued by the governmental authority having jurisdiction over civil aviation in the country of registry.

Aggregate Deductible means an amount of Covered Expenses which must be paid by the Policyholder for all Insureds covered under the Policy before the Policy will pay the Excess Medical Expense benefits. Only Covered Expenses for a Covered Loss for an Injury that occurs during the Policy Term will be applied to the Aggregate Deductible.

Common Carrier or **Public Conveyance** means:

1. a Conveyance, including Aircraft, licensed for hire to carry fare-paying passengers; or
2. a transport Aircraft operated by the Air Mobility Command of the United States of America or similar air transport service of another country.

Company means Fidelity Security Life Insurance Company.

Confined or **Confinement** means the Insured is admitted to a facility as a registered bed patient and at least one day's room and board is charged. The Confinement must be Medically Necessary and be ordered by a Physician.

Confinement does not include treatment received in a Hospital emergency room, an observation room, a free-standing surgical facility or the outpatient department of a Hospital.

Conveyance means a motorized craft, vehicle or mode of transportation licensed or registered by a governmental authority.

Covered Activity or **Covered Activities** means an activity shown in the Schedule of Benefits that is sponsored, organized, scheduled or otherwise provided by the Policyholder. The Covered Activity must be a part of a Covered Sport.

Covered Expense or **Covered Expenses** means Medically Necessary expenses incurred by or on behalf of an Insured due to an Injury for the treatment, services, or supplies covered under the Policy. The expense must be due to an Injury that occurs while the Insured is participating in a Covered Activity related to a Covered Sport.

Covered Expenses are deemed incurred on the date the treatment is rendered or the service is given.

Covered Loss means a loss payable under the Policy for an Injury that occurs during a Covered Activity related to a Covered Sport.

Covered Sport means a sport shown in the Schedule of Benefits that is sponsored, organized, scheduled or otherwise provided by the Policyholder.

Effective Date means, for the Policy, the date shown in the Policy face page. Effective Date means, for an Insured, the date the Insured becomes covered under the Policy as shown in the Company's records. The Effective Date will begin at 12:01 a.m. Local Time at the Policyholder's business address.

Expanded Cheerleading means cheering or participating in supervised and sponsored fund-raisers, alumni events, camps, clinics, competitions and any activity for which the participating school has requested the cheerleading squad's attendance or participation.

Health Maintenance Organization (HMO) means any organized system of health care that provides health maintenance and treatment services for a fixed sum of money agreed and paid in advance to the provider of service.

Home Office means the Company's office located at 3130 Broadway, Kansas City, Missouri, 64111-2406.

Hospital means an institution that meets all the following requirements:

1. it must be operated according to law;
2. it must give 24-hour medical care, diagnosis and treatment to the sick or injured on an Inpatient basis;
3. it must provide diagnostic and surgical facilities supervised by a Physician;
4. registered Nurses must be on 24-hour call or duty; and
5. the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

Hospital does not mean a convalescent, nursing, rest or extended care facility or a facility operated exclusively for treatment of the aged, drug addict or alcoholic, even though such facility is operated as a separate institution by a Hospital.

Immediate Family means an Insured or an Insured's spouse, domestic partner, parent, child, grandparent, brother, sister, in-law, step or any person residing in the Insured's home.

Injury means bodily Injury sustained by an Insured due to an Accident, directly and independently of all other causes, that occurs while the Policy is in force. All Injuries sustained by an Insured in any one Accident are considered a single Injury.

Inpatient means the Insured is Confined when covered services are received.

Insured means a person who is in an Eligible Class as defined by the Policyholder for whom premium has been paid and whose coverage under the Policy has become effective and has not ended. The Eligible Classes are shown in the Schedule of Benefits.

Intercollegiate Sport means a sport which:

1. has been accorded varsity status by the Policyholder;
2. is administered by the Policyholder's department of intercollegiate athletics for which the eligibility of the participating student athlete is reviewed and certified in accordance with the applicable intercollegiate sports organization's legislation, rules or regulations; and
3. entitles qualified participants to receive the Policyholder's official awards.

Medically Necessary means that a service or supply is necessary and appropriate for the diagnosis or treatment of an Injury based on generally accepted current medical practice. A service or supply will not be considered Medically Necessary if:

1. it is provided only as a convenience to the Insured or provider;
2. it is not appropriate treatment for the Insured's diagnosis or symptoms;
3. it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or
4. it is part of a plan of treatment that is experimental, unproven or related to a research protocol.

The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

Non-Preferred Provider means a Hospital, Physician, or other health care provider which is not a member of an HMO or PPO plan.

Nurse means a licensed graduate Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.). He or she may not be the Insured, a member of the Insured's Immediate Family or a person employed or retained by the Policyholder.

Other Healthcare Plan means any arrangement, which provides benefits or services for healthcare, dental care, disability benefits or repatriations of remains. Other Healthcare Plan includes, but is not limited to, group or blanket insurance plans; group Blue Cross Blue Shield, or other group prepayment coverage plans; coverage provided through automobile "fault" or "no fault" insurance; or coverage under labor-management trusteed plans, union welfare plans, employer organizational plans, employee benefit organizational plans, self-funded plans or other arrangements of benefits for persons of a group. Other Healthcare Plan does not include TRICARE, Medicare or Medicaid.

Outpatient means the Insured is not Confined when covered services are received.

Physician means a person licensed by the state in which he or she is a resident to practice the healing arts. He or she must be practicing within the scope of his or her license for the service or treatment given. He or she may not be the Insured, a member of the Insured's Immediate Family or a person employed or retained by the Policyholder.

Policy Term means the 12-month period beginning on the Policy Effective Date and ending on the Policy Expiration Date, or the actual period of time during which the Policy is in force if the Policy terminates prior to the Expiration Date.

Policyholder means the entity in whose name the Policy is issued.

Pre-Existing Injury means an Injury that occurred before the Insured's coverage became effective under the Policy and:

1. was treated by a Physician or treatment had been recommended by a Physician;
2. required taking prescribed drugs or medicines; or
3. first manifested itself, worsened, became acute or exhibited symptoms that would have caused an ordinarily prudent person to seek diagnosis.

Preferred Provider Organization (PPO) means an organization offering health care services through designated health care providers who have agreed to perform these services at a rate negotiated between the health care provider and the PPO.

Private Passenger Automobile means a validly registered, four-wheel private passenger vehicle, including Policyholder-owned cars, campers, motor homes, station wagons, sport utility vehicles, pick-up trucks and van-type cars that are not licensed commercially or being used for commercial purposes. Any vehicle being used as a taxi cab, bus or other Public Conveyance will not be considered a Private Passenger Automobile.

Schedule of Benefits means the page which gives basic information referenced in the Policy.

Scheduled Airlines or **Scheduled Aircraft** means any carrier holding a certificate, license or similar authorization for civilian scheduled air transport issued by the country of the Aircraft's registry, and which, in accordance with that authorization flies, maintains and publishes schedules and tariffs for regular passenger service between named cities at regular and specified times, but only if the Aircraft is then used for any regular or chartered flight operated by such carrier.

Sickness means a disease or illness, or more than one disease or illness, resulting from the same or related causes or conditions, including all complications thereof and all related conditions and recurrences.

Standard Cheerleading means cheering at competition or exhibition game, practice session and pep rally if authorized by, organized by and directly supervised by an official coach or advisor of the Policyholder and in preparation for a competition of a Covered Sport. Standard Cheerleading does not include camps, clinics, competitions, fund-raisers, alumni events, or any event not conducted by the Policyholder.

Supervised and Sponsored Sports Activities mean any activity related to a Covered Sport. The Covered Sport must:

1. take place on the Policyholder's premises during scheduled hours;
2. take place at another site at which the activity is scheduled; or
3. be sponsored, organized or otherwise provided by the Policyholder.

In addition, the Covered Activity must be supervised by a coach, referee or by another adult specifically assigned supervisory duties and authority for that activity by the Policyholder.

Travel means transportation on a Common Carrier or Private Passenger Automobile driven by an adult with a valid drivers' license whom the Policyholder has specifically designated to transport Insureds to a Covered Activity. It must be direct and without interruption:

1. between home and the premises of the Policyholder;
2. between home and another meeting place designated by the Policyholder;
3. between home and another site designated by the Policyholder, where a Covered Activity is scheduled; or
4. between the premises of the Policyholder or other meeting place it designates, and another site where a Covered Activity is scheduled.

It includes transportation to a Covered Activity when the Insured's participation or attendance requires the Insured to be away from the Insured's normal residence for a stay of one or more nights.

Usual and Customary Charges means the lesser of the actual charge billed or the allowable charge negotiated by an Other Healthcare Plan. If the Insured is not covered under an Other Healthcare Plan, it will be the lesser of the actual charge billed or 100% of the Medicare eligible expenses.

ELIGIBILITY AND EFFECTIVE DATE

New eligible persons will be added from time to time. In no event will coverage for any person become effective before the Policy Effective Date.

Insured Eligibility and Effective Date. Eligibility requirements are defined in the Policyholder's application. Coverage will be effective on the date the Insured becomes a member of an Eligible Class as shown in the Schedule of Benefits subject to payment of the first premium.

BENEFITS

The following benefits are payable for Eligible Class(es) of Insureds who are covered under the Policy as shown in the Schedule of Benefits, subject to the terms, conditions, limitations, exclusions and Schedule of Benefits. The Covered Loss must occur while the Insured is participating in a Covered Activity related to a Covered Sport.

Accidental Death and Dismemberment. If a covered Injury results in the Insured suffering any one of the Losses listed below, the Company will pay the listed benefit. The Principal Sum is shown in the Schedule of Benefits.

The Insured must be covered by this Policy at the time of the Accident. The loss must occur within 365 days of the date of the Accident.

Loss of	Benefit
Life	Principal Sum
Both Hands	Principal Sum
Both Feet	Principal Sum
Sight of Both Eyes	Principal Sum
One Hand and One Foot	Principal Sum
Speech and Hearing in Both Ears	Principal Sum
One Hand and Sight of One Eye	Principal Sum
One Foot and Sight of One Eye	Principal Sum
One Hand	50% of Principal Sum
One Foot	50% of Principal Sum
Sight of One Eye	50% of Principal Sum
Speech	50% of Principal Sum
Hearing in Both Ears	50% of Principal Sum
Use of Both Arms and Legs	100% of Principal Sum
Use of One Arm and One Leg	75% of Principal Sum
Use of One Arm or One Leg	50% of Principal Sum
Thumb and Index Finger of Same Hand	25% of Principal Sum
Loss of all Four Fingers of the Same Hand	25% of Principal Sum
Loss of all Toes of the Same Foot	25% of Principal Sum

If more than one loss occurs due to the same Accident, the Company will only pay one benefit amount not to exceed the amount payable for the greater of the two Losses.

For purposes of this benefit, the following definitions apply:

"Loss of a Foot" means complete Severance through or above ankle joint.

"Loss of a Hand" means complete Severance through or above the wrist.

"Loss of Hearing" means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means.

"Loss of Sight" means the total, permanent Loss of Sight of one eye. The Loss of Sight must be irrecoverable by natural, surgical or artificial means.

"Loss of Speech" means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means.

"Loss of a Thumb" and Index Finger of the Same Hand or Loss of Four Fingers of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

"Loss of Toes" means complete Severance through the metatarsophalangeal joint.

"Loss of Use" means the total loss of movement or total feeling in the arm including the hand, or in the leg including the foot, and the loss is determined by a Physician to be total and irrecoverable.

"Severance" means complete separation and dismemberment of the part from the body.

Exposure and Disappearance. If the Insured is Exposed and as a result of such exposure suffers a Loss for which an Accidental Death or Accidental Dismemberment Benefit is otherwise payable under the Policy, the Company will pay the listed benefit.

If the body of an Insured has not been found following a Disappearance, the Company will pay the Loss of Life benefit under the Accidental Death and Dismemberment benefit.

For purposes of this benefit, the following definitions apply:

"Disappearance" means the Insured's body has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a Conveyance in which the Insured was an occupant while covered under this Policy while participating in a Covered Activity related to a Covered Sport while covered under the Policy.

"Exposed" or "Exposure" means the Insured is unavoidably exposed to the elements which is a direct result from a Covered Activity related to a Covered Sport while covered under the Policy.

Excess Accident Medical Expense Benefit. Benefits are payable at the percentage of Usual and Customary Charges shown in the Schedule of Benefits for the Covered Expenses listed below that are incurred by an Insured due to an Injury related to a Covered Activity that are in excess of any similar benefits the Insured is eligible for due to the same accident under any Other Healthcare Plans. Benefits are payable up to the Maximum Benefit Amount, subject to the Aggregate Deductible shown in the Schedule of Benefits and are paid without regard to any coordination of benefits provision in any Other Healthcare Plan.

The first Covered Expense must be incurred within the number of days shown in the Schedule of Benefits from the date of the Accident. Covered Expenses must be incurred before the end of the Maximum Benefit Period which begins on the date of the Accident. If an Insured suffers an Injury prior to the Policy Expiration Date, benefits continue to be payable for Covered Expenses until the earlier of:

1. the date the Maximum Benefit Period is reached; or
2. the date the Maximum Benefit Amount is paid.

Inpatient Hospital Room and Board. Hospital Confinement in a semi-private room or an intensive care unit of a Hospital.

Miscellaneous Expenses. Miscellaneous expenses charged by a Hospital or ambulatory surgical center for Outpatient surgery. Miscellaneous expenses include, but are not limited to: X-ray, laboratory, In-Hospital physiotherapy, Nurse services, orthopedic appliances, pre-admission tests and all necessary charges other than room and board, for services received during a Hospital stay. Miscellaneous expenses do not include personal supplies and services, such as barber or beautician services and television when provided during a Hospital stay.

Ambulatory Medical Center. Medical or surgical treatment provided in a licensed facility providing ambulatory surgical or medical treatment that is not part of a Hospital or Physician's office.

Emergency Room Treatment. Outpatient emergency room treatment performed in a Hospital.

Surgery.

1. Surgical procedure. Two or more surgical procedures performed through the same incision will be considered as one procedure. However, the Company will pay up to 50% of the Usual and Customary Charge for a second surgical procedure when performed through different incisions during the same surgical session;
2. An assistant surgeon assisting a Physician performing a surgical procedure;
3. Treatment of fractured and dislocated bones, operations that involve cutting or incision or suturing of wounds or any other surgical procedure, including aftercare, which is given in the Outpatient department of a Hospital or an ambulatory surgical center; and
4. Any braces, splints or other devices required after surgery to ensure proper healing.

Physician's Surgical Facilities. The use of the Physician's surgical facilities.

Second Opinion or Consultation. A Physician for a second surgical opinion or consultation.

Physician's Assistant. A Physician's Assistant, other than pre- or post-operative care, second opinion or consultation, for:

1. In-Hospital visits; and
2. office visits.

Anesthesia. A Physician for anesthesia and its administration.

In-Hospital or Office Visits. A Physician, other than pre- or post-operative care, second opinion or consultation, for:

1. In-Hospital visits; and
2. office visits.

Outpatient X-ray, CT Scan, MRI and Laboratory Tests. Outpatient X-rays, except dental X-rays, CT Scans, MRI's, and laboratory tests.

Outpatient Physiotherapy. Outpatient Physiotherapy. For this benefit, "Physiotherapy" means acupuncture, microthermy, manipulation, diathermy, massage therapy, heat treatment, and ultrasonic treatment.

Outpatient Nursing Services. Outpatient services rendered by a Nurse.

Ambulance Services. Ground or air ambulance service to transport the Insured from the place where the Accident occurred to the nearest medical facility or to another appropriate medical facility, if a Physician specifies in writing that specialized care is not available in the first facility to treat the Injuries.

Medical Equipment Rental. Rental or, if less, purchase of:

1. a wheelchair or Hospital bed; or
2. other medical equipment that has permanent or temporary therapeutic value for the Insured and that can only be used by the Insured. Permanent or temporary therapeutic value is determined by the Physician.

Medical Equipment Rental does not include computers, motor vehicles and modifications thereof, ramps, installation costs, eyeglasses and hearing aids.

Medical Services and Supplies. Blood and blood transfusions, including processing and administration; and cost and administration of oxygen and other gases.

Medical Services and Supplies does not include the cost of storage of blood for any reason.

Dental Services. Dental treatment for Injury to a tooth:

1. with no fillings or cavities or only fillings or cavities that do not undermine the tooth cusps;
2. for which pulpal tissues are healthy and intact; and
3. for which periodontal tissue shows little or no signs of active or chronic inflammation. For insurance review purposes, each tooth unit is evaluated under these criteria rather than a blanket rating of the whole mouth.

Covered Expenses include examinations, X-rays, restorative treatment, endodontics, oral surgery and initial braces required for treatment of an Injury and treatment of gingivitis resulting from trauma.

If there is more than one way to treat a dental problem, the Company will pay based on the least expensive procedure if that procedure meets commonly accepted standards of the American Dental Association.

Prescription Drugs. Drugs that: (a) can only be obtained through a Physician's written prescription; and (b) are approved for such prescription use by the Federal Drug Administration (FDA). The Company will also pay Medically Necessary Covered Expenses incurred for drugs that meet all of the above and are prescribed by a Physician for therapeutic use not specifically approved by the FDA.

Covered Expense for a prescription drug is limited to the cost of a generic drug unless:

1. substitution of a generic drug is prohibited by law;
2. no generic drug is available; or
3. the Insured's Physician specifically requests that a non-generic drug be dispensed to the Insured.

Expanded Medical Benefit for Covered Sports Conditions. The Excess Accident Medical Expense Benefit is payable for Covered Expenses for the treatment of bursitis, sprain, hernia, muscle tears, tendonitis and repetitive motion injuries if they are aggravated by the Insured's participation in a Covered Activity related to a Covered Sport. Benefits are subject to the same maximums, limitations and deductible as for an Injury.

Heart and Circulatory Benefit. The Excess Accident Medical Expense Benefit is payable for Covered Expenses for the treatment of heat exhaustion, heart attack, cardiac arrest, stroke, or burst aneurysm if the conditions occur and are manifested during a Covered Activity. This benefit does not include coverage for hypertension or angina. The condition must be first diagnosed and treated while the Insured's coverage under the Policy is in force and occur while participating or within 24 hours following participation in a Covered Activity related to a Covered Sport. With the exception of heat exhaustion, the Insured must have been released to play if before such participation the Insured has been medically advised of or received any medical treatment for such heart malfunction. Benefits are subject to the same maximums, limitations and deductible as for an Injury.

HMO/PPO Denial Benefit. The Excess Accident Medical Expense Benefit is payable for Covered Expenses when benefits are denied or reduced by an HMO or PPO plan because services provided to treat the Injury were:

1. rendered by a Non-Preferred Provider; or
2. received outside of the network's service area.

If benefits are reduced rather than denied by an HMO or PPO for the reasons described above, the Company will pay an amount equal to the Medically Necessary Covered Expense incurred less the amount paid by the HMO or PPO. Benefits are subject to the same maximums, limitations and deductible as for an Injury.

Pre-Existing Injury Benefit. The Excess Accident Medical Expense Benefit is payable for Covered Expenses for the treatment of an aggravation or re-injury of a Pre-Existing Injury. Benefits are subject to the same maximums, limitations and deductible as for an Injury.

Non-Duplication of Benefits. This provision applies if:

1. the Insured is covered by any Other Healthcare Plan; and
2. payment of benefits would exceed the expenses actually incurred by the Insured.

In this case, the Covered Expenses payable under the Policy will be reduced by the excess amount of benefits. The total amount of benefits payable under the Other Healthcare Plan and the Policy will not exceed 100% of the actual expenses incurred.

LIMITATIONS AND EXCLUSIONS

Limitations

Accidental Death and Dismemberment Aggregate Policy Limit for Common Accident. If two or more Insureds are injured in one common Accident, the total maximum benefits payable for all Insureds for the Accidental Death and Dismemberment benefit under the Policy are limited to an Aggregate Policy Limit for Common Accident. The Aggregate Policy Limit for Common Accident is shown in the Schedule or Benefits.

If the Aggregate Policy Limit for Common Accident Limit cannot pay the full amount of each claim to each Insured or beneficiary, the amount of each claim will be paid in the same proportion that each claim has to the Aggregate Policy Limit for Common Accident.

The Company is not liable for any benefit payments in excess of this Aggregate Policy Limit for Common Accident.

Exclusions

The Policy does not provide any benefits for the following:

1. suicide or any attempt of suicide, while sane or insane;
2. any intentionally self-inflicted Injury or Sickness or any attempt thereat;
3. committing, attempting to commit or taking part in a felony, battery, assault or engaging in an illegal occupation;
4. Participation in a Riot, insurrection, rebellion, civil commotion, civil disobedience or unlawful assembly. For purposes of this exclusion, "Participation" means to take an active part in common with others; "Riot" means any use or threat to use force or violence or disturbance by three or more persons without authority of law. This does not include a loss that occurs while acting in a lawful manner within the scope of authority;
5. declared or undeclared war or act of war or any act of declared or undeclared war. This does not include acts of terrorism;
6. flight in, boarding or alighting from an Aircraft, except as a passenger on a regularly scheduled commercial airline;
7. travel in any Aircraft owned, leased operated or controlled by the Policyholder, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;
8. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, (including exposure, whether or not Accidental, to viral, bacterial or chemical agents) whether the loss results directly or non-directly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound or Accidental ingestion of contaminated food;
9. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
10. Injury payable under any Workers' Compensation Law, Occupational Disease Law or similar law, whether or not application for such benefits have been made;
11. operating any type of vehicle or Conveyance while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Insured has been provided a written warning against operating a vehicle or Conveyance while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the motor vehicle laws of the state in which the Loss occurred;
12. the Insured's intoxication. The Insured is conclusively deemed to be intoxicated if the level in the Insured's blood exceeds the amount at which a person is presumed, under the law of the locale in which the Accident occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether the Insured is in fact operating a motor vehicle, when the Injury occurs. An autopsy report from a licensed medical examiner, law enforcement officer's report, or similar items will be considered proof of the Insured's intoxication;
13. an Accident if the Insured is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: (a) the Insured holds a valid learners permit and (b) the Insured is receiving instruction from a driver's education instructor;
14. medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice, unless it occurs during treatment of an Injury;
15. Losses that occur during any activity that is not sponsored, organized, supervised, scheduled or otherwise provided by the Policyholder; or
16. if Travel is included as a Covered Activity, Losses that occur:
    a. during travel to or from any activity if the Policyholder provides transportation to and from it for a group of two or more persons and the Insured is travelling to or from it by another means of transportation;
    b. during any activity that is not reasonably related to the Insured's covered travel; or
    c. during any activity that is not incidental to the purpose of a covered trip.

Exclusions for the Excess Accident Medical Expense Benefit
In addition to the above Exclusions, Benefits will not be payable for the Excess Accident Medical Expense Benefit for:

1. treatment, services or supplies not Medically Necessary, or in excess of the Usual and Customary amount;
2. sales tax or gross receipt tax, or any charges to complete a claim form;
3. any expense for which there is no legal obligation to pay, no charge is made or in the absence of coverage, no charge would be made;
4. personal comfort items such as telephone, television or similar services;
5. cosmetic surgery, except for reconstructive surgery needed as the result of an Injury;
6. any elective or routine treatment, surgery, health treatment, or examination, including any service, treatment of supplies that: (a) that is considered by the U.S. Department of Health and Human Services or any of its agencies to be experimental or investigational; and (b) are not recognized and generally accepted medical practice in the United States;
7. examination or prescriptions for, or purchase, repair or replacement of, eyeglasses, contact lenses, hearing aids, wheelchairs, braces, appliances, orthopedic braces, or orthotic devices;
8. treatment in any Veteran's Administration, Federal, or state facility, unless there is a legal obligation to pay;
9. services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay;
10. rest cures or custodial care which do not assist the Insured to recover form an Injury;
11. repair or replacement of existing dentures, partial dentures, braces or bridgework;
12. orthopedic appliances used mainly to protect an Injury so that the Insured can take part in interscholastic, intercollegiate and club sports;
13. expenses payable by any automobile insurance policy without regard to fault;
14. treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) regardless of the means by which it was acquired; or
15. repair or replacement of existing artificial limbs, eyes and larynx.

TERMINATION OF INSURANCE

Termination of the Policy. The Policy may be terminated on the first of the following dates:

1. any date on or after the date the Company receives the Policyholder's written request for termination;
2. the date the required premium has not been paid, except as provided in the Grace Period provision; or
3. the Policy Expiration Date.

The Policyholder is responsible for notifying the Insured of the termination of the Policy.

Termination of the insurance of any Insured will be without prejudice to any Accident or Injury originating before the date of termination.

Termination of Insured's Coverage under the Policy. An Insured's coverage under the Policy automatically ends on the first of the following dates:

1. the date the Policy terminates;
2. the date the required premium has not been paid, except as provided in the Grace Period provision; or
3. the date the Insured is no longer in an Eligible Class.

CLAIM PROVISIONS

Notice of Claim. Written notice of claim must be given to the Company within 30 days after a covered Loss occurs, or as soon after that as is reasonably possible. Notice must be given by or on behalf of the claimant to the Company at 3130 Broadway, Kansas City, Missouri 64111-2406, or to its authorized administrator or to any of the Company's authorized agents. Notice must include the name of the Insured, the Policy Number and the nature of the loss.

Claim Forms. The Company will furnish claim forms to the Insured within 15 days after notice of claim is received. If the Company does not send the forms within that time, the Insured can send written proof of the occurrence, character and extent of loss for which the claim is made, within the time stated in the Policy for filing proof of loss.

Proof of Loss. Written proof of loss must be furnished to the Company at the Company's home office within 90 days after the date of the loss. Failure to furnish proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within that time, if the proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted later than one year from the time proof is required.

Time Payment of Claims. Any benefit payable under the Policy will be paid immediately upon receipt of due written proof of loss.

Payment of Claims. All benefits will be payable to the Insured, unless assigned. Any benefits payable on or after the Insured's death, unless assigned, will be paid to the first of the following living persons:

1. the Insured's spouse;
2. the Insured's children, equally;
3. the Insured's parents, equally; or
4. the Insured's brothers and sisters, equally.

If none of the above persons is living on the date of the Insured's death, the Company will pay the benefits to the Insured's estate.

If any benefit is payable to an estate or to a minor or person not otherwise competent to give a valid release, the Company may pay such benefit, up to the amount allowed by the law of the state in which the minor or incompetent resides. Such payment will be made to the legal guardian of the minor or incompetent. Any payment made by the Company in good faith under this provision will fully discharge the Company to the extent of the payment.

Assignment. Benefits under the Policy may be assigned.

Right of Recovery. To the extent that benefits are provided or paid under the Policy the Insured agrees that if the Insured fully recovers the Insured's damages from a third party, then the Insured will reimburse the Company the portion of the damages recovered for the expenses incurred by the Insured that were provided or paid by the Company. The Company agrees to pay the Company's portion of the Insured's attorneys' fee or other costs associated with a claim or lawsuit to the extent that the Company recovers any portion of the benefits paid under the Policy pursuant to Company's right of reimbursement.

Subrogation. To the extent that benefits are provided or paid under the Policy, the Company will be subrogated to all rights of recovery which any Insured may acquire against any other party for the recovery of the amount paid under the Policy, however the Company's right of subrogation is secondary to the right of the Insured to be fully compensated for the Insured's damages. The Insured agrees to deliver all necessary documents or papers, to execute and deliver all necessary instruments, to furnish information and assistance, and to take any action the Company may require to facilitate enforcement of our right of subrogation. The Company agrees to pay our portion of the Insured's attorneys' fee or other costs associated with a claim or lawsuit to the extent that the Company recovers any portion of the benefits paid under the Policy pursuant to the Company's right of subrogation.

Physical Examination and Autopsy. The Company, at the Company's expense, will have the right and opportunity to examine any Insured for whom a claim is pending when and as often as it may reasonably be required during the pendency of a claim. The Company, at the Company's expense, will have the right to make an autopsy in case of death, unless it is forbidden by law.

Legal Actions. No Insured can bring an action at law or in equity to recover on the Policy until more than 60 days after the date written proof of loss has been furnished according to the Policy. No such action may be brought after the expiration of three years after the time written proof of loss is required to be furnished. If the time limit of the Policy is less than allowed by the laws of the state where the Insured lives, the limit is extended to meet the minimum time allowed by such law.

GENERAL PROVISIONS

Certificates. The Company will furnish a Certificate to the Policyholder for the Insured. The Certificate will describe the coverage provided, to whom benefits are paid and the provisions of the Policy that apply to the Insured. The Certificate is not a part of the Policy. Any conflict between the terms of the Certificate and the Policy will be decided in favor of the Policy. A copy of the Policy may be examined at the office of the Policyholder.

Choice of Physician. The Insured is free to be treated by any Physician the Insured chooses.

Clerical Error. Clerical errors or delays in keeping records for the Policy will not deny insurance that would otherwise have been granted, nor extend insurance that otherwise would have ceased and call for a fair adjustment of premium and benefits to correct the error.

Conformity to Law. Any provision of the Policy that is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

Entire Contract. The entire contract between the parties includes the Policy, any endorsement and riders, the Policyholder's application (that is attached to the Policy when issued) and the Insured's individual enrollment form, if any. All statements made by the Policyholder or an Insured will, in the absence of fraud, be deemed representations and not warranties, and no such statement will be used in defense of a claim hereunder unless it is contained in a written instrument signed by the Policyholder, the Insured, the Insured's beneficiary or personal representative, a copy of which has been furnished to the Policyholder, the Insured, the Insured's beneficiary or personal representative.

Amendments and Changes. No agent is authorized to alter or amend the Policy, or to waive any conditions or restrictions herein, or to extend the time for paying a premium. The Policy and the Certificate may be amended at any time, in writing, by mutual agreement between the Policyholder and the Company without the consent of the Insured, but without prejudice to any loss incurred prior to the effective date of the amendment. No person except an Officer of the Company has authority on behalf of the Company to modify the Policy or to waive or lapse any of the Company's rights or requirements.

Incontestability. After the Policy has been in force for two years, it can only be contested for nonpayment of premiums. No statement made by an Insured can be used in a contest after the Insured's insurance has been in force for two years during the Insured's lifetime. No statement an Insured makes can be used in a contest unless it is in writing and signed by the Insured.

Insurance Data. The Policyholder must give the Company the names and ages of all individuals initially insured. The names of persons who later become eligible (whether or not they become insured), and the names of those who cease to be eligible must also be given. The eligibility dates and any other necessary data must be given to the Company so that the premium can be determined.

The Company has the right to audit the Policyholder's books and records as they relate to this insurance. The Company can authorize someone else to perform the audit. Any such inspection may be done at any reasonable time.

Other Insurance with This Insurer. Insurance that is effective at any one time on the Insured under a similar contract, policy or rider with the Company is limited to the one such plan elected by the Insured, the Insured's beneficiary or the Insured's estate. The Company will return all premiums paid for all other such plans issued after the first plan became effective.

Workers' Compensation. The Policy is not a Workers' Compensation policy. The Policy does not satisfy any requirement for coverage by Workers' Compensation Insurance.

COMMERCIAL CASUALTY INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

STUDENT HEALTH CERTIFICATE OF COVERAGE

POLICYHOLDER:	SOUTHEASTERN LOUISIANA UNIVERSITY (Policyholder)
POLICY NUMBER:	CCIC1920LASHIP114
POLICY EFFECTIVE DATE:	August 1, 2019
POLICY TERMINATION DATE:	July 31, 2020
STATE OF ISSUE:	Louisiana

This Certificate of Coverage ("Certificate") explains the benefits available to You under a Policy between Commercial Casualty Insurance Company (hereinafter referred to as "We", "Us" or "Our") and the Policyholder. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

INSURING AGREEMENTS

COVERAGE: Benefits are provided to cover the expenses incurred due to a Covered Sickness or a Covered Injury which results in Covered Medical Expenses.

We will pay the benefits under the terms of the Policy in consideration of:
1. The application for the Policy; and
2. The payment of all premiums as set forth in the Policy.

This Certificate takes effect on the effective date at 12:00 a.m. local time at the Policyholder's address. We must receive the Policyholder's signed application and the initial Premium for it to take place.

Term of the Certificate
This Certificate terminates at 11:59 p.m. local time at the Policyholder's address.

The following pages form a part of this Certificate as fully as if the signatures below were on each page.

This Certificate is executed for the Company by its President and Secretary.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THIS CERTIFICATE. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

Non-Participating
Non-Renewable

President
Andrew M. DiGiorgio

Secretary
Angela Adams

Underwritten by:	Commercial Casualty Insurance Company 5814 Reed Road Fort Wayne, IN 46835
Administrator:	Wellfleet Group, LLC PO Box 15369 Springfield, MA 01115-5369 877-657-5030

NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

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SCHEDULE OF BENEFITS

Preventive Services:
In-Network Provider: The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of the Negotiated Charge when services are provided through an In-Network Provider.

Out-of-Network Provider: Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through an Out-of-Network Provider. Benefits are paid at 60% of the Usual and Customary Charge.

Medical Deductible*

In-Network Provider	Individual:	$250
Out-of-Network Provider	Individual:	$500

Cost sharing You incur for Covered Medical Expenses that is applied to the Out-of-Network Deductible will not be applied to satisfy the In-Network Deductible. Cost sharing You incur for Covered Medical Expenses that is applied to the In-Network Deductible will not be applied to satisfy the Out-of-Network Provider Deductible.

Out-of-Pocket Maximum:	In-Network Provider	Individual	$5,000
	Out-of-Network Provider	Individual	$10,000

Cost sharing You incur for Covered Medical Expenses that is applied to the Out-of-Network Provider Out-of-Pocket Maximum will not be applied to satisfy the In-Network Provider Out-of-Pocket Maximum and cost sharing You incur for Covered Medical expenses that is applied to the In-Network Provider Out-of-Pocket Maximum will not be applied to satisfy the Out-of-Network Provider Out-of-Pocket Maximum.

Coinsurance Amounts:

In-Network Provider:	80% of the Negotiated Charge for Covered Medical Expenses unless otherwise stated below.
Out-of-Network Provider:	60% of the Usual and Customary Charge (U&C) for Covered Medical Expenses unless otherwise stated below.

Medical Benefit Payments for In-Network Providers and Out-of-Network Providers
This Certificate provides benefits based on the type of health care provider You selects. This Certificate provides access to both In-Network Providers and Out-of-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by In-Network Providers versus Out-of-Network Providers, as shown in the Schedule of Benefits.

Dental and Vision Benefit Payments
For dental and vision benefits, You may choose any dental or vision provider.

For dental, different benefits may be payable based on the type of service, as shown in the Schedule of Benefits.

Preferred Provider Organization:
To locate an In-Network Provider in Your area, consult Your Provider Directory or call toll free (877) 657-5030 or visit Our website at www.wellfleetstudent.com.

NOTICE: HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTH CARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR CO-PAYMENTS, COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES.

SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT THE WEBSITE ADDRESS OF YOUR HEALTH PLAN OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER OF YOUR HEALTH PLAN.

THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL BE:

1. **THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;**
2. **ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND**
3. **DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY AN IN-NETWORK OR OUT-OF-NETWORK PROVIDER.**
4. **UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN DEDUCTIBLE WILL ALWAYS APPLY.**

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Inpatient Benefits		
Hospital Care Includes hospital room & board expenses and miscellaneous services and supplies. Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care. Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Visits while Confined: Limited to 1 visit per day of Confinement per provider	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Surgery: Pre-Certification Required		
Surgeon Services	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Anesthetist	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Assistant Surgeon	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Registered Nurse Services for private duty nursing while Confined	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Up to $1,000 maximum per Policy Year		
Physical Therapy while Confined (inpatient)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Certification required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
INPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER		
Mental Health Disorder and Substance Use Disorder Benefit Pre-Certification Required In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, and any Pre-certification requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Benefits		
Outpatient Surgery: Pre-Certification required Surgeon Services	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Anesthetist	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Assistant Surgeon	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Surgery Facility and Miscellaneous expenses for services &	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma		
Physician's Office Visits	$25 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	$25 Copayment per visit then the plan pays 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Specialist/Consultant Physician Services	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telemedicine or Telehealth Services	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Cardiac Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Habilitative Services including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Services rendered in a Hospital Emergency Room	$150 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses Copayment waived if admitted	Paid the same as In-Network Provider subject to Usual and Customary Charge.
Urgent Care Centers	$25 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	$25 Copayment per visit then the plan pays 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Diagnostic Imaging Services	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
CT Scan, MRI and/or PET Scans	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Laboratory Procedures (Outpatient)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Health Care Expenses	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hospice Care Coverage	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Private Duty Nursing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
OUTPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER		
Mental Health Disorder and Substance Use Disorder Benefit In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, and any Pre-Certification requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Prescription Drugs Retail Pharmacy No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy.		
TIER 1 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$10 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$10 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$20 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Retail pharmacy	$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$30 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
TIER 2 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$15 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$15 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$30 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Retail pharmacy	$45 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	$45 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses

	Deductible Waived	Deductible Waived
TIER 3 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail Pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$30 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$60 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Retail pharmacy	$90 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$90 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
Zero Cost Generics		
	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	100% of Actual charge for Covered Medical Expenses Deductible Waived
Specialty Prescription Drugs		
Specialty Prescription Drugs For each fill up to a 30 day supply	$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$50 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
More than a 30 day supply but less than a 61 day supply	$100 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$100 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply	$150 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$150 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
Orally administered anti-cancer prescription drugs (including specialty drugs)		

Benefit	Greater of: • Chemotherapy Benefit; or • Infusion Therapy Benefit	
Diabetic Supplies (for Prescription supplies purchased at a pharmacy)		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill	
Other Benefits		
Allergy Testing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Allergy Injections/Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Ambulance Service ground and/or air, water transportation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Covered Clinical Trials	Same as any other Covered Sickness	
Durable Medical Equipment Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diabetic services and supplies (including equipment and training) Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hearing Aids	100% of the Negotiated Charge after Deductible for Covered Medical Expenses Deductible Waived	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	
Enteral Formulas and Nutritional Supplements See the Prescription Drug section of this Schedule when purchased at a pharmacy.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Prosthetic and Orthotic Devices Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Reconstructive Surgery Pre-Certification Required	Covered the same as any other Surgery	Covered the same as any other Surgery
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19)	See the Pediatric Dental Care Benefit description in the Certificate for further information.	
Preventive Dental Care Limited to 2 dental exams every 12 months The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care:	100% of Usual and Customary Charge	
Emergency Dental	50% of Usual and Customary Charge	
Routine Dental Care	50% of Usual and Customary Charge	
Endodontic Services	50% of Usual and Customary Charge	
Prosthodontic Services	50% of Usual and Customary Charge	
Periodontic Services	50% of Usual and Customary Charge	
Medically Necessary Orthodontic Care Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. For an all-inclusive list of pediatric dental benefits provided to the end of the month in which the Insured Person turns age 19: https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-codes/2014/brochures/MetLife.pdf	50% of Usual and Customary Charge	
Pediatric Vision Care Benefit (to the end of the	100% of Usual and Customary Charge after Deductible for Covered Medical Expenses	

month in which the Insured Person turns age 19) Limited to 1 visit(s) per Policy Year and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. For an all-inclusive list of pediatric vision benefits provided to the end of the month in which the Insured Person turns age 19: https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-codes/2014/brochures/FEPBlueVi.pdf		
Accidental Injury Dental Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Pre-Certification Required	$25 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	$25 Copayment per visit then the plan pays 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Organ Transplant Surgery travel and lodging expenses a maximum of $2,000 per Policy Year or $250 per day, whichever is less while at the transplant facility. Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Shots and Injections unless considered Preventive Services	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Sports Accident Expense - incurred as the result of the play or practice of Intercollegiate sports Up to $5000 per Accident	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Non-emergency Care While Traveling Outside of the United States	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses Subject to $10,000 maximum per Policy Year	
Medical Evacuation Expense	100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived Subject to $50,000 maximum per Policy Year	
Repatriation Expense	100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived Subject to $50,000 maximum per Policy Year	
Interpreter Services for the Deaf and Hard of Hearing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Sleep Studies	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Lymphedema Benefit	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Oral Surgery Benefits	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Mandated Benefits		
Attention Deficit Disorder	Same as any other Covered Sickness, subject to the following limitations: Benefits for attention deficit/hyperactivity disorder provided for an initial diagnosis shall not exceed six hundred dollars ($600); Services rendered on an outpatient basis shall not exceed fifty dollars ($50) per visit with a Physician or other appropriate health care provider and total benefits shall be limited to ten thousand dollars ($10,000) during an Insured Person's lifetime, and shall not exceed twenty-five hundred dollars ($2,500) in any given Policy Year.	
Autism Spectrum Disorder	Same as any other Covered Sickness	
Bone Mass Measurement	Same as any other Covered Sickness	
Cancer Screening	Same as any other Preventive Service	
Cleft Lip and Cleft Palate Coverage	Same as any other Covered Sickness	
Dental Anesthesia	Same as any other Covered Sickness	
Outpatient Registered Dietician	Same as any other Covered Sickness	

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Principal Sum $10,000

Loss must occur within 180 days of the date of a covered Accident.

Only one benefit will be payable under this provision, that providing the largest benefit, when more than one (1) loss occurs as the result of any one (1) Accident. This benefit is payable in addition to any other benefits payable under this Certificate.

SECTION I - ELIGIBILITY

An eligible student must attend classes at the Policyholder's school for at least the first 31 days of the period for which he or she is enrolled and/or pursuant to his or her visa requirements for the period for which coverage is elected.

Except in the case of withdrawal from school due to Sickness or Injury, any student who withdraws from the Policyholder's school during the first 31 days of the period for which he or she is enrolled shall not be covered under the insurance plan. A full refund of Premium will be made, minus the cost of any claim benefits paid by the Certificate. A student who graduates or withdraws after such 31 days of the period for which he or she is enrolled will remain covered under this Certificate for the term purchased and no refund will be allowed.

A student withdrawing due to a medical withdrawal due to a Sickness or Injury, must submit documentation or certification of the medical withdrawal to Us at least 30 days prior to the medical leave of absence from the school, if the medical reason for the absence and the absence are foreseeable, or 30 days after the date of the medical leave from school. The student withdrawing due to a medical withdrawal due to a Sickness or Injury will remain covered under the Certificate for the term purchased and no refund will be allowed.

All International Students are required to have a J-1, F-1 or M-1 Visa to be eligible for this insurance plan.

We maintain the right to investigate eligibility status and attendance records to verify that the Certificate eligibility requirements have been and continue to be met. If We discover that the Certificate eligibility requirements have not been met, Our only obligation is refund of premium less any claims paid.

Eligibility requirements must be met each time premium is paid to continue Coverage.

If You performed an act that constitutes fraud; or You have made an intentional misrepresentation of material fact during Your enrollment under this insurance plan in order to obtain coverage for a service, coverage will be terminated immediately upon written notice of termination delivered by Us to You.

Who is Eligible

Class	Description of Class(es)
1	All domestic and international undergraduate and graduate NCAA student athletes registered for 12 credits or more

Class 1: All students, as determined by the Policyholder, are eligible for coverage under the Policy. Eligible students are required to have health insurance coverage and will be automatically enrolled in the Student Health Insurance Plan and the premium will be added to the student's tuition fees unless proof of comparable coverage is provided by completing the waiver.

Who is not Eligible

The following students are not eligible to enroll in the insurance plan:

- students enrolled exclusively in online courses or whose enrollment consists entirely of short-term courses;
- students taking distance learning, home study, correspondence, television courses, or courses taken for audit do not fulfill the eligibility requirements that the student actively attend classes. The online restriction does not apply to students who are completing their degree requirements while engaged in practical training.

Dependents are not eligible for coverage under this plan.

SECTION II - EFFECTIVE AND TERMINATION DATES

Effective Dates: Your Insurance under this Certificate will become effective on the later of:

1. The Policy Effective Date;

2. The beginning date of the term of coverage for which premium has been paid;
3. The day after Enrollment (if applicable) and premium payment is received by Us, Our authorized agent or the School;
4. The day after the date of postmark if the Enrollment form is mailed; or
5. For International Students, the departure date to his or her Home Country to travel to the Country of Assignment. The scheduled arrival in the Country of Assignment must be not more than 48 hours later than the departure from the Home Country.

Special Enrollment - Qualifying Life Event
You, can also enroll for coverage within 60 days of the loss of coverage in a health plan if coverage was terminated because You are no longer eligible for coverage under the other health plan due to:

1. Involuntary termination of the other health plan;
2. Death of the Spouse;
3. Legal separation, divorce or annulment;
4. A Child no longer qualifies for coverage as a Child under the other health plan.

You can also enroll 60 days from exhaustion of Your COBRA or continuation coverage.

We must receive notice and Premium payment within 60 days of the loss of coverage. The effective date of Your coverage will depend on when We receive proof of Your loss of coverage under another health plan and appropriate premium payment. Your coverage shall take effect on the latest of the following dates: (1) this Policy Effective Date; (2) the day after the date for which You lose Your coverage providing premium for Your coverage has been paid; (3) the date the Policyholder's term of coverage begins; or (4) the date You become a member of an eligible class of persons.

In addition, You can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. You lose eligibility for Medicaid or a state child health plan.
2. You become eligible for Medicaid or a state child health plan.

We must receive notice and Premium payment within 60 days of the loss of 1 of these events. The effective date of Your coverage will depend on the date We receive Your completed enrollment information and required premium.

Termination Dates: Your insurance will terminate on the earliest of:

1. The date this Certificate terminates; or
2. The end of the period of coverage for which premium has been paid; or
3. The date You cease to be eligible for the insurance; or
4. The date You enter military service or
5. For International Students, the date they cease to meet Visa requirements; or
6. For International Students, the date they depart the Country of Assignment for their Home Country (except for scheduled school breaks)); or
7. On any premium due date the Policyholder fails to pay the required premium for You except as the result of an inadvertent error and subject to any Grace Period provision.

Dependent Child Coverage:

Newly Born Children - A newly born child of Yours will be covered from the moment of birth. Such newborn child will be covered for Covered Injury or Covered Sickness for an initial period of 31 days. This includes the necessary care and Treatment of medically diagnosed congenital defects and birth abnormalities from the moment of birth. Dependent coverage is not available under this plan. When this 31 day provision has been exhausted, all Dependent coverage ends. No further benefits will be paid.

Extension of Benefits: Coverage under this Certificate ceases on the Termination Date of Your insurance coverage. However, coverage for You will be extended as follows:

1. If You have been diagnosed with a life-threatening illness, or are Hospital Confined for Covered Injury or Covered Sickness on the date Your insurance coverage terminates, We will continue to pay benefits for up to 90 days from the Termination Date while such Confinement continues.

Reinstatement Of Reservist After Release From Active Duty: If Your insurance ends due to Your being called or ordered to active duty, such insurance will be reinstated without any waiting period when You return to School and satisfy the eligibility requirements defined by the School or College.

Refund of Premium: Premiums received by Us are fully earned upon receipt. Refund of Premium will be considered only:

1. If a student ceases to be eligible for the insurance and coverage is terminated prior to the next premium due date, a pro rata refund of Premium (less any claims paid) will be made for such person.
2. For any student who withdraws from school during the first 31 days of the period for which he or she is enrolled for a reason other than withdrawal due to Sickness or Injury. Such a student will not be covered under this Certificate and a full refund of the Premium will be made (less any claims paid) when written request is made within 90 days of withdrawal from school.
3. For an Insured Student entering the Armed Forces of any country. Such a student will not be covered under this Certificate as of the date of his/her entry into the service. A pro rata refund of Premium (less any claims paid) will be made upon written request received by Us within 90 days of withdrawal from school.
4. For an Insured International Student departing school to return to his or her Home Country on a permanent basis. We will refund a pro rata refund of Premium (less any claims paid) when written request is received by Us within 60 days of such departure.

SECTION III – DEFINITIONS

These are key words used in this Certificate. They are used to describe the Policyholder's rights as well as Ours. Reference should be made to these words as the Certificate is read.

Accident means a sudden, unforeseeable external event which directly and from no other cause, results in an Injury.

Actual Charge means the charge for the Treatment by the provider who furnishes it.

Ambulance Service means transportation to or from a Hospital by a licensed Ambulance whether ground, air or water Ambulance, in a Medical Emergency.

Ambulatory Surgical Center means a facility which meets licensing and other legal requirements and which:

1. Is equipped and operated to provide medical care and Treatment by a Physician;
2. Does not provide services or accommodations for overnight stays;
3. Has a medical staff that is supervised full-time by a Physician;
4. Has full-time services of a licensed registered nurse at all times when patients are in the facility;
5. Has at least one operating room and one recovery room and is equipped to support any surgery performed;
6. Has x-ray and laboratory diagnostic facilities;
7. Maintains a medical record for each patient; and
8. Has a written agreement with at least one Hospital for the immediate transfer of patients who develop complications or need Confinement.

Anesthetist means a Physician or Nurse who administers anesthesia during a surgical procedure. He or she may not be an employee of the Hospital where the surgical procedure is performed.

Assistant Surgeon means a Physician who assists the Surgeon who actually performs a surgical procedure.

Brand-Name Prescription Drug means a Prescription Drug whose manufacture and sale is controlled by a single company as a result of a patent or similar right. Refer to the Formulary for the tier status.

Certificate: The Certificate issued by Us, including the Schedule of Benefits and any attached riders.

Coinsurance means the percentage of Covered Medical Expenses that We pay. The Coinsurance percentage is stated in the Schedule of Benefits. The Coinsurance is separate and not part of the Deductible and Copayment.

Complications of Pregnancy means conditions that require Hospital Confinements before the pregnancy ends and whose diagnoses are distinct from but caused or affected by pregnancy. These conditions are acute nephritis or nephrosis, cardiac decompensation, missed abortion, or similar conditions as severe as these.

Complications of Pregnancy also include non-elective cesarean section, termination of an ectopic pregnancy, and spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.)

Complications of Pregnancy do not include false labor, occasional spotting or Physician prescribed rest during the period of pregnancy, morning Sickness, preeclampsia, and similar conditions not medically distinct from a difficult pregnancy.

Confinement/Confined means an uninterrupted stay following admission to a health care facility. The readmission to a health care facility for the same or related condition, within a 7 day period, will be considered a continuation of the Confinement. Confinement does not include observation, which is a review or assessment of 48 hours or less, of a condition that does not result in admission to a Hospital or health care facility.

Copayment means a specified dollar amount You must pay for specified Covered Medical Expenses. Any Copayment amounts are shown in the Schedule of Benefits.

Country of Assignment means the country in which an Eligible International Student, scholar or visiting faculty member is:

1. Temporarily residing; and
2. Actively engaged in education or educational research related activities sponsored by the National Association for Foreign Student Affairs or its Member Organizations.

Covered Injury/Injury means a bodily injury due to an unforeseeable, external event which results independently of disease, bodily infirmity or any other cause. All injuries sustained in any one Accident, all related conditions and recurrent symptoms of these injuries are considered a single Injury.

Covered Medical Expense means those Medically Necessary charges for any Treatment, service, or supplies that are:

1. Not in excess of the Usual and Customary Charge therefore;
2. Not in excess of the charges that would have been made in the absence of this insurance;
3. Not in excess of the Negotiated Charge; and
4. Incurred while Your Certificate is in force, except with respect to any expenses payable under the Extension of Benefits Provision.

Covered Sickness means an illness, disease or condition including pregnancy and Complications of Pregnancy that impairs Your normal function of mind or body and which is not the direct result of an Injury which results in Covered Medical Expenses. Covered Sickness includes Mental Health Disorders and Substance Use Disorders.

Custodial Care means care that is mainly for the purpose of meeting non-medical personal needs. This includes help with activities of daily living and taking medications. Activities of daily living include: bathing, dressing or grooming, eating, toileting, walking and getting in and out of bed. Custodial Care can usually be provided by someone without professional and medical skills or training.

Deductible means the dollar amount of Covered Medical Expenses You must pay before benefits are payable under this Certificate. The amount of the Deductible, if any, will be shown in the Schedule of Benefits.

Dental provider means any individual legally qualified to provide dental services or supplies.

Durable Medical Equipment means a device which:
1. Is primarily and customarily used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of Sickness or Injury and is able to withstand repeated use;
2. Is used exclusively by You;
3. Is routinely used in a Hospital but can be used effectively in a non-medical facility;
4. Can be expected to make a meaningful contribution to treating Your Sickness or Injury; and
5. Is prescribed by a Physician and the device is Medically Necessary for rehabilitation.

Durable Medical Equipment does not include:
1. Comfort and convenience items;
2. Equipment that can be used by Immediate Family Members other than You;
3. Health exercise equipment; and
4. Equipment that may increase the value of Your residence.

Effective Date means the date coverage becomes effective.

Elective Surgery or Elective Treatment means those health care services or supplies not Medically Necessary for the care and Treatment of a Covered Injury or Covered Sickness. Elective surgery does not include Plastic, Cosmetic, or Reconstructive Surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

Eligible Student means a student who meets all eligibility requirements of the School named as the Policyholder.

Emergency Medical Condition means a Covered Sickness or Injury for which immediate medical Treatment is sought at the nearest available facility. The Condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:
1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition: transportation services, including but not limited to ambulance services, and covered inpatient and outpatient Hospital services furnished by a Hospital or Physician qualified to furnish those services necessary to screen, evaluate and Stabilize an Emergency Medical Condition.

Essential Health Benefits mean benefits that are defined in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes the following categories of Covered Services:
1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and Substance Use Disorder services, including behavioral health Treatment;
6. Prescription drugs;
7. Rehabilitative and Habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

Experimental/Investigative means the service or supply has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication. For further explanation, see definition of Medically Necessary/Medical Necessity provision.

Inpatient Rehabilitation Facility means a licensed institution devoted to providing medical and nursing, care over a prolonged period, such as during the course of the rehabilitation phase after an acute sickness or injury.

Formulary means a list of medications designed to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost-effective medications. The Formulary indicates the type of drug and tier status.

Generic Prescription Drug means any Prescription Drug that is not a Brand-Name Prescription Drug. Refer to the Formulary for the tier status.

Habilitation/Habilitative Services means health care services that help You keep, learn, or improve skills and functions for daily living. Habilitative Services may include such services as Physical Therapy, occupational therapy, and speech therapy.

Home Country means Your country of citizenship. If You have dual citizenship, Your Home Country is the country of the passport You used to enter the United States.

Home Health Care Agency means an agency that:

1. Is constituted, licensed and operated under the provision of Title XVIII of the Federal Social Security Act, or qualified to be so operated if application was made, and certified by the jurisdiction in which the Home Health Care plan is established; and
2. Is engaged primarily in providing skilled nursing facility services and other therapeutic services in Your Home under the supervision of a Physician or a Nurse; and
3. Maintains clinical records on all patients.

Home Health Care means the continued care and treatment if:

1. Your institutionalization would have been required if Home Health Care was not provided; and
2. Your Physician establishes and approves in writing the plan of treatment covering the Home Health Care service; and
3. Home Health Care is provided by:
   a. a Hospital that has a valid operating certificate and is certified to provide Home Health Care services; or
   b. a public or private health service or agency that is licensed as a Home Health Agency under title 19, subtitle 4 of the General Health Article to provide coordinated Home Health Care.

Hospice: means a coordinated plan of home and Inpatient care which treats the terminally ill patient and family as a unit. It provides care to meet the special needs of a family unit during the final stages of a terminal illness and during the bereavement. Care is provided by a team of: trained medical personnel, homemakers, and counselors. The team acts under an independent Hospice administration. It helps the family unit cope with: physical, psychological, spiritual, social, and economic stresses.

Hospital: A facility which provides diagnosis, treatment, and care of persons who need acute Inpatient Hospital care under the supervision of Physicians and provides 24-hour nursing service by Registered Nurses on duty or call. It must be licensed as a general acute care Hospital according to state and local laws. Hospital shall also include a psychiatric health facility for the treatment of mental or psychoneurotic disorders. Hospital also includes tax- supported institutions, which are not required to maintain surgical facilities.

Hospital also includes an Ambulatory Surgical Center or ambulatory medical center; and a birthing facility certified and licensed as such under the laws where located. It shall also include Rehabilitative facilities if such is specifically required for Treatment of physical disability.

Facilities primarily treating drug addiction or Alcoholism that are licensed to provide these services are also included in this definition. Hospital does not include a place primarily for rest, the aged, a place for educational or Custodial Care or Hospice.

Immediate Family Member means You and Your spouse or the parent, child, brother or sister of You or Your spouses.

In-Network Providers are Physicians, Hospitals and other healthcare providers who have contracted with Us to provide specific medical care at negotiated prices.

Insured Person means an Insured Student while insured under this Certificate.

Insured Student means a student of the Policyholder who is eligible and insured for coverage under this Certificate.

International Student means an international student:
1. With a current passport and a student Visa;
2. Who is temporarily residing outside of his or her Home Country; and
3. Is actively engaged as a student or in educational research activities through the Policyholder.

In so far as this Certificate is concerned, permanent residents or those who have applied for Permanent Residency Status are not considered to be an International Student.

Loss means medical expense caused by an Injury or Sickness which is covered by this Certificate.

Medically Necessary or **Medical Necessity** means health care services that a Physician, exercising prudent clinical judgment, would provide for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
1. In accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for an illness, injury or disease; and
3. not primarily for the convenience of an Insured Person, Physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or Treatment of an Insured Person's illness, injury or disease.

The fact that any particular Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

Mental Health Disorder means a condition or disorder that substantially limits the life activities of an Insured Person with the disorder. Mental Health Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization.

Negotiated Charge means the amount an In-Network Provider will accept as payment in full for Covered Medical Expenses.

Nurse means a licensed Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who:
1. Is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
2. Provides medical services which are within the scope of the Nurse's license or certificate who does not ordinarily reside in Your home or is not related to You by blood or marriage.

Organ Transplant means the moving of an organ from one (1) body to another or from a donor site to another location of the person's own body, to replace the recipient's damaged, absent or malfunctioning organ.

Out-of-Network Providers are Physicians, Hospitals and other healthcare providers who have not agreed to any pre-arranged fee schedules.

Out-of-Pocket Maximum means the most You will pay during a Policy Year before Your Coverage begins to pay 100% of the allowed amount. Refer to the Out-of-Pocket Maximum in the Description of Benefits section for details on how the Out-of-Pocket Maximum applies. This limit will never include Premium, balance-billed charges

or health care this Certificate does not cover.

Physical Therapy means any form of the following:
1. Physical or mechanical therapy;
2. Diathermy;
3. Ultra-sonic therapy;
4. Heat Treatment in any form; or
5. Manipulation or massage.

Physician means a health care professional practicing within the scope of his or her license and is duly licensed by the appropriate state regulatory agency to perform a particular service which is covered under this Certificate, and who is not:
1. You;
2. An Immediate Family Member; or
3. A person employed or retained by You.

Policy Year means the period of time measured from the Policy Effective Date to the Policy Termination Date.

Preadmission Testing means tests done in conjunction with and within 5 days of a scheduled surgery where an operating room has been reserved before the tests are done.

Qualifying Life Event means an event that qualifies a Student to apply for coverage for him/herself due to a Qualifying Life Event under this Certificate.

Rehabilitative means the process of restoring Your ability to live and work after a disabling condition by:
1. Helping You achieve the maximum possible physical and psychological fitness;
2. Helping You regain the ability to care for Yourself;
3. Offering assistance with relearning skills needed in everyday activities, with occupational training and guidance with psychological readjustment.

Reservist means a member of a reserve component of the Armed Forces of the United States. Reservists also includes a member of the State National Guard and the State Air National Guard.

School or College means the college or university attended by the Insured Student.

Skilled Nursing Facility means a facility, licensed, and operated as set forth in applicable state law, which:
1. Mainly provides inpatient care and Treatment for persons who are recovering from an illness or injury;
2. Provides care supervised by a Physician;
3. Provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
4. Is not a place primarily for the care of the aged, Custodial or Domiciliary Care, or Treatment of alcohol or drug dependency; and
5. Is not a rest, educational, or custodial facility or similar place.

Sound, Natural Teeth means natural teeth. The major portion of a tooth must be present, regardless of fillings, and not carious, abscessed or defective. Sound, Natural Teeth will not include capped teeth.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical Treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Substance Use Disorder means any condition or disorder that substantially limits the life activities of an Insured Person with the disorder. Substance Use Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization.

Surgeon means a Physician who actually performs surgical procedures.

Telemedicine means the practice of health care delivery, diagnosis, consultation, Treatment, transfer of medical data, and education using interactive audio, video, or data communications involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information. Neither a telephone conversation nor an electronic messaging between a Physician and You constitutes "Telemedicine".

Temporarily Medically Disabled Mother means transportation by professional ambulance services for the temporarily medically disabled mother of the ill newly born when accompanying the ill newly born to the nearest available hospital or neonatal special care unit. The mother's need for professional ambulance service must be certified by her attending Physician.

Treatment means the medical care of a Covered Injury or Covered Sickness by a Physician who is operating within the scope of his or her license. Such care includes diagnostic, medical, surgical or therapeutic services, medical advice, consultation, recommendation, and/or the taking of drugs or medicines or the prescriptions thereof.

Urgent Care means short-term medical care performed in an Urgent Care Facility for non-life-threatening conditions that can be mitigated or require care within 48 hours of onset.

Urgent Care Facility means a Hospital or other licensed facility which provides diagnosis, Treatment, and care of persons who need acute care under the supervision of Physicians.

Usual and Customary Charge is the amount of an Out-of-Network provider's charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

The Usual and Customary Charge depends on the geographic area where You receive the service or supply. The table below shows the method for calculating the Usual and Customary Charge for specific services or supplies:

Service or Supply	Usual and Customary Charge
Professional services and other services or supplies not mentioned below	The Reasonable amount rate
Services of hospitals and other facilities	The Reasonable amount rate

Special terms used

- Geographic area is normally based on the first 3 digits of the U.S. Postal Service zip codes. If We determine We need more data for a particular service or supply, We may base rates on a wider geographic area such as an entire state.
- "Reasonable amount rate" means Your plan has established a reasonable rate amount as follows:

Service or Supply	Reasonable Amount Rate
Professional services and Inpatient and outpatient charges of hospitals	The lesser of: 1. The billed charge for the services. 2. An amount determined using current publicly-available data which is usual and customary when compared with the charges made for a) similar services and supplies and b) to persons having similar medical conditions in the geographic area where service is rendered. 3 An amount based on information provided by a third party vendor, which may reflect 1 or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable providers' fees and costs to deliver care.

Our reimbursement policies
We reserve the right to apply our reimbursement policies to all Out-of-Network services including involuntary services. Our reimbursement policies may affect the Usual and Customary Charge. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the provider

Our reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of Physicians and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

No payment will be made under this Certificate for any expenses incurred which, in Our judgment, are in excess of Usual and Customary Charges.

You, or Your(s) means an Insured Person, Insured Student while insured under this Certificate.

Visa means the document issued by the United States Government that permits an individual to participate in the educational activities of a college, university or other institution of higher learning either as a student or in another academic capacity. An International Student must have and maintain a valid visa, either an F-1 (Academic), J-1 (Exchange) or M-1(Vocational) in order to continue as a student in the United States.

We, Us, or **Our** means Commercial Casualty Insurance Company or its authorized agent. Also referred to as the Company.

SECTION IV – HOW THE PLAN WORKS AND DESCRIPTION OF BENEFITS

Schedule of Benefits
The following are shown in the Schedule of Benefits:

- Deductible;
- Any specified benefit maximums;
- Coinsurance percentages;
- Copayment amounts; and
- Out-of-Pocket Maximums.

How the Deductible Works

Deductible
The Deductible amount (if any) is shown in the Schedule of Benefits. This dollar amount is what You have to incur in Covered Medical Expenses before benefits are payable under this Certificate. This amount will apply on an individual basis. The Deductible applies to all Covered Medical Expenses, unless specifically noted. Any expenses that You incur that are not Covered Medical Expenses are not applied toward Your Deductible.

Covered Medical Expenses applied to the In-Network Provider Policy Year Deductible will not apply to the Out-of-Network Provider Policy Year Deductible. Covered Medical Expenses applied to the Out-of-Network Provider Policy Year Deductible will not apply to the In-Network Provider Policy Year Deductible.

Individual
The Deductible is an amount the individual must incur for In-Network Provider and Out-of-Network Provider Covered Medical Expenses before the plan pays. This Deductible applies separately to You. After the amount of Covered Medical Expenses You incur reaches the Policy Year Deductible, this plan will pay for Covered Medical Expenses as shown on the Schedule of Benefits for the rest of the Policy Year.

Coinsurance is the percentage of Covered Medical Expenses that We pay. The Coinsurance percentage is stated in the Schedule of Benefits. The Coinsurance is separate and not part of the Deductible and Copayment.

Copayment is a specified dollar amount You must pay for specified Covered Medical Expenses. Any Copayment amounts are shown in the Schedule of Benefits.

How Your Out-of-Pocket Maximum Works

The In-Network Provider and Out-of-Network Provider Out-of-Pocket Maximums are shown in the Schedule of Benefits. The Out-of-Pocket Maximum provides is the amount of Covered Medical Expenses You have to incur before Covered Medical Expense will be paid at 100% for the reminder of the Policy Year subject to any benefit maximums or limits that may apply. Any applicable Coinsurance amounts, Deductibles and Copayments will apply toward the Out-of-Pocket Maximum.

Services that are not Covered Medical Expenses, balance-billed charges and premium do not count toward meeting the Out-of-Pocket Maximum.

Covered Medical Expenses applied to the In-Network Provider Out-of-Pocket Maximum(s) will not be applied to satisfy the Out-of-Network Provider Out-of-Pocket Maximum and Covered Medical Expenses applied to the Out-of-Network Provider Out-of-Pocket Maximum will not be applied to satisfy the In-Network Provider Out-of-Pocket Maximum.

The Out-of-Pocket Maximum is the maximum amount of Covered Medical Expenses You will incur for Copayments, Coinsurance and Policy Year Deductibles during the Policy Year. This plan has an individual Out-of-Pocket Maximum. As to the individual Out-of-Pocket Maximum, each of You must meet Your Out-of-Pocket Maximum separately.

Individual

Once the amount of the Copayments, Coinsurance and Policy Year Deductibles You have incurred for Covered Medical Expenses during the Policy Year meets the:

- In-Network Provider individual Out-of-Pocket Maximum, this plan will pay:
  - 100% of the Negotiated Charge for In-Network Provider Covered Medical Expenses
- Out-of-Network Provider individual Out-of-Pocket Maximum, this plan will pay:
  - 100% of the Usual and Customary Charge for Out-of-Network Covered Medical Expenses

that apply towards the limits for the rest of the Policy Year for that covered individual.

The Out-of-Pocket Maximum is the maximum amount of Covered Medical Expenses You are responsible to incur during the Policy Year. This plan has an individual Out-of-Pocket Maximum.

The Out-of-Pocket Maximum may not apply to certain Covered Medical Expenses. If the Out-of-Pocket Maximum does not apply to a covered benefit, Your Copayment and Coinsurance for that medical expense will not count toward satisfying the Out-of-Pocket Maximum.

Essential Health Benefits
Essential Health Benefits are not subject to annual or lifetime dollar limits. If additional specific care, Treatment or services are added to the list of Essential Health Benefits by a governing authority, the Certificate benefits will be amended to comply with such changes.

Treatment of Covered Injury and Covered Sickness Benefit
If:
1. You incur expenses as the result of Covered Injury or Covered Sickness, then
2. We will pay the benefits stated in the Schedule of Benefits for the services, Treatments and supplies described in the Covered Medical Expenses provision below.

Payment will be made, subject to the Coinsurance, Deductible, Copayment, maximums and limits as stated in the Schedule of Benefits:
1. For The Usual and Customary Charge or the Negotiated Charge for Covered Medical Expenses that are incurred as the result of a Covered Injury or Covered Sickness; and
2. Subject to the Exclusions and Limitations provision.

Medical Benefit Payments for In-Network Provider and Out-of-Network Provider
This Certificate provides benefits based on the type of health care provider You select. This Certificate provides access to both In-Network Providers and Out-of-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by In-Network Providers versus Out-of-Network Providers, as shown in the Schedule of Benefits.

Dental and Vision Benefit Payments
For dental and vision benefits, You may choose any dental or vision provider.

For dental, different benefits may be payable based on type of service, as shown in the Schedule of Benefits.

Preferred Provider Organization
If You use an In-Network Provider, this Certificate will pay the Coinsurance percentage of the Negotiated Charge for Covered Medical Expenses shown in the Schedule of Benefits for Covered Medical Expenses.

If an Out-of-Network Provider is used, this Certificate will pay the percentage of the Usual and Customary Charge for Covered Medical Expenses shown in the Schedule of Benefits. The difference between the provider fee and the Coinsurance amount paid by Us will be Your responsibility.

Note, however, that We will pay at the In-Network level for Treatment by an Out-of-Network Provider and will calculate Your cost sharing amount at the In-Network Provider level if:

1. there is no In-Network Provider in the service area available to treat You for a specific Covered Injury or Covered Sickness; or
2. there is an Emergency Medical Condition and You cannot reasonably reach an In-Network Provider; or
3. You receive services rendered by an Out-of-Network provider at an In-Network Provider facility during:
   - A service or procedure performed by an In-Network Provider; or
   - During a service or procedure previously approved or authorized by Us and You did not knowingly elect to obtain such services from the Out-of-Network provider.

You should be aware that In-Network Hospitals may be staffed with Out-of-Network Providers. Receiving services from an In-Network Hospital does not guarantee that all charges will be paid at the In-Network Provider level of benefits. It is important that You verify that Your Physicians are In-Network Providers each time You call for an appointment or at the time of service.

Continuity of Care

If You are undergoing an active course of Treatment with an In-Network Provider, You may request continuation of Treatment by such In-Network Provider in the event the In-Network Provider's contract has terminated with the Preferred Provider organization. We shall notify You of the termination of the In-Network Provider's contract at least 60 days in advance. When circumstances related to the termination render such notice impossible, We shall provide affected enrollees as much notice as is reasonably possible. The notice given must include instructions on obtaining an alternate provider and must offer Our assistance with obtaining an alternate provider and ensuring that there is no inappropriate disruption in Your ongoing Treatment. We shall permit You to continue to be covered, with respect to the course of Treatment with the provider, for a transitional period of at least 60 days from the date of the notice to You of the termination except that if You are in the second trimester of pregnancy at the time of the termination and the provider is treating You during the pregnancy or if You have a life-threatening illness. The transitional period must extend through the provision of postpartum care directly related to the pregnancy. Life-threatening illness means a severe, serious, or acute condition for which death is probable.

Continuation of Treatment by a Preferred Provider is not required when:

1. In-Network Provider termination is due to suspension, revocation, or applicable restriction of their license to practice in the state of LA by the Louisiana State Board of Medical Examiners, or for another documented reason related to quality of care;
2. You choose to change Providers;
3. You move out of the geographic service area;
4. You require only routine monitoring for a chronic condition but is not in an acute phase of Your condition.

Pre-Certification Process

In-Network - Your In-Network Provider is responsible for obtaining any necessary Pre-certification before You receive the care. If Your In-Network Provider does not obtain the required Pre-Certification You will not be penalized. Please read below regarding review and notification.

Out-of-Network - You or Your Out-of-Network Provider are responsible for calling Us at the phone number found on the back of Your ID card and starting the Pre-Certification process. For Inpatient services the call must be made at least 5 working days prior to Hospital Confinement. For Outpatient services, the call must be made at least 5 working days prior to the start of the Outpatient service. In the case of an emergency, the call must take place as soon as reasonably possible.

The following Inpatient and Outpatient services or supplies require Pre-Certification:

1. All Inpatient admissions, including length of stay, to a Hospital, Skilled Nursing Facility, a facility established primarily for the Treatment of a substance use disorder, or a residential Treatment facility;
2. All Inpatient maternity care after the initial 48/96 hours;
3. All partial hospitalization in a Hospital, residential Treatment facility, or facility established primarily for the Treatment of substance abuse;
4. Durable Medical Equipment over $500;
5. Surgery;

6. Sleep Management;
7. Transplant Services;
8. Infusions/injectables;
9. Botox Injections;
10. Genetic Testing, except for Bracca;
11. Orthotics/prosthetics;
12. Transcranial Magnetic Stimulation (TMS);
13. Physical Therapy (Outpatient) precertification required after the 12th visit;
14. Occupational Therapy (Outpatient) precertification required after the 12th visit;
15. Chiropractic Services (Outpatient) precertification required after the 12th visit.

Pre-Certification is not required for an Emergency Medical Condition or Urgent Care or Hospital Confinement for the initial 48/96 hours of maternity care.

Additionally, no authorization requirement will apply to obstetrical or gynecological care provided by In-Network Providers.

Pre-Certification is not a guarantee that Benefits will be paid.

Your Physician will be notified of Our decision as follows:
1. For elective (non-emergency) admissions to a health care facility, We will notify the Physician and the health care facility by telephone and/or in writing of the number of Inpatient days, if any, approved;
2. For Confinement in a health care facility longer than the originally approved number of days, the treating Physician or the health care facility must contact Us before the last approved day. We will review the request for continued stay to determine Medical Necessity and notify the Physician or the health care facility of Our decision in writing or by telephone;
3. For any other covered services requiring Pre-Certification, We will contact the Provider in writing or by telephone regarding Our decision.

Our agent will make this determination within 72 hours for an urgent request and 4 business days for non-urgent requests following receipt of all necessary information for review. Notice of an Adverse Benefit Determination made by Our agent will be in writing and will include:
1. The reasons for the Adverse Benefit Determination including the clinical rationale, if any.
2. Instructions on how to initiate an appeal.
3. Notice of the availability, upon Your request or Your Authorized Representative, of the clinical review criteria relied upon to make the Adverse Benefit Determination. This notice will specify what, if any additional necessary information must be provided to, or obtained by, Our agent in order to render a decision on any requested appeal.

Failure by Our agent to make a determination within the time periods prescribed shall be deemed to be an Adverse Benefit Determination subject to an appeal.

If You have any questions about Your Pre-Certification status, You should contact Your Provider.

COVERED MEDICAL EXPENSES

We will pay for the following Covered Medical Expenses when they are incurred as the result of a Covered Injury or Covered Sickness.

Preventive Services

The following services shall be covered without regard to any Deductible, Coinsurance or Copayment requirement that would otherwise apply when provided by an In-Network Provider :
1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices

(ACIP) of the Centers for Disease Control and Prevention.

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
4. With respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
5. Outpatient/office contraceptive services are covered, provided that the services are related to the use of FDA approved contraceptives. Examples of covered contraceptive services are: office visits, consultations, examinations and services related to the use of federal legend oral contraception or IUD insertion, diaphragm fitting, vasectomy or contraceptive injections. Please note that prescription and nonprescription contraceptive drugs and devices (such as oral contraceptives, IUDs, diaphragms, and contraceptive injections) are covered under the Prescription Drug Benefit. See Prescription Drugs for information on those services and devices.

Important Notes:

1. These Preventive Services recommendations and guidelines may be updated periodically. When these are updated, they will be applied to this plan. The updates will be effective on the first day of the calendar year, one year after the updated recommendation or guideline is issued.
2. Diagnostic testing for the treatment or diagnosis of a Covered Injury or Covered Sickness will not be covered under the Preventive Services. For those types of tests and Treatment, You will pay the cost sharing specific to Covered Medical Expense for diagnostic testing and Treatment.
3. This plan will not limit gender-specific Preventive Services based on Your gender at birth, Your identity, or according to other records.

To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact Your Physician or contact Us by calling the number on Your ID card. This information can also be found at the https://www.healthcare.gov/ website.

We may use reasonable medical management techniques to determine the frequency, method, Treatment, or setting of Preventive Services benefits when not specified in the recommendations and guidelines of the:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP)
- United States Preventive Services Task Force (USPSTF)
- Health Resources and Services Administration (HRSA)
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

Inpatient Benefits

1. **Hospital Care**- Covered Medical Expenses include the following:
   - Room and Board Expense, including general nursing care. Benefit may not exceed the daily semi-private room rate unless intensive care unit is required.
   - Intensive Care Unit, including 24-hour nursing care.
   - Hospital Miscellaneous Expenses, while Hospital Confined or as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as:
     a. The cost for use of an operating room;
     b. Prescribed medicines (excluding take-home drugs);
     c. Laboratory tests;
     d. Therapeutic services;
     e. X-ray examinations;
     f. Casts and temporary surgical appliances;
     g. Oxygen, oxygen tent; and
     h. Blood and blood plasma.

2. **Preadmission Testing** for routine tests performed as a preliminary to Your being admitted to a Hospital. These tests must be performed within 5 working days prior to admission. This benefit is limited to routine tests such as complete blood count, urinalysis, and chest x-rays. Unless otherwise payable under this Certificate, We will pay for

major diagnostic procedures under the Hospital Miscellaneous Expense Benefit. This includes tests such as CAT scans, cardiac catheterization, MRI's, NMR's, and blood chemistries.

3. **Physician's Visits while Confined** not to exceed 1 visit per day of confinement per provider. Physician's visits will be paid for either inpatient or outpatient visits when incurred on the same day, but not both. Surgeon's fees are not payable under this benefit.

4. **Inpatient Surgery including Surgeon, Anesthetist, and Assistant Surgeon Services** (including pre- and post-operative visits) as specified in the Schedule of Benefits. Covered surgical expenses will be paid under either the inpatient surgery benefit or the Outpatient Surgery Benefit. They will not be paid under both. This benefit is not payable in addition to Physician's visits.

   Sometimes 2 or more surgical procedures can be performed during the same operation.
   1. **Through the Same Incision.** If Covered multiple surgical procedures are performed through the same incision, We will pay for the procedure with the highest allowed amount and 50% of the amount We would otherwise pay under this Certificate for the secondary procedures, except for secondary procedures that, according to nationally-recognized coding rules, are exempt from multiple surgical procedure reductions. We will not pay anything for a secondary procedure that is billed with a primary procedure when that secondary procedure is incidental to the primary procedure.

   2. **Through Different Incisions.** If Covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay:
      - For the procedure with the highest allowed amount; and
      - 50% of the amount We would otherwise pay for the other procedures.

5. **Registered Nurse's Services while confined,** when private duty nursing care is prescribed by the attending Physician. General nursing care provided by the Hospital is not covered under this benefit.

6. **Physical Therapy while Confined** when prescribed by the attending Physician.

7. **Skilled Nursing Facility Benefit** for services received in a licensed Skilled Nursing Facility. Services must be Medically Necessary. Confinement for Custodial Care or residential care is not covered.

8. **Inpatient Rehabilitation Facility Expense Benefit** for the services, supplies and Treatments rendered to You in an **Inpatient Rehabilitation** Facility. You must enter an **Inpatient Rehabilitation** Facility:
   a. Within 7 days after Your discharge from a Hospital Confinement;
   b. Such Confinement must be of at least 3 consecutive days that began while coverage was in force under this Certificate; and
   c. Was for the same or related Sickness or Accident.

   Services, supplies and Treatments by an **Inpatient Rehabilitation** Facility include:
   a. Charges for room, board, and general nursing services
   b. Charges for physical, occupational, or speech therapy;
   c. Charges for drugs, biologicals, supplies, appliances, and equipment for use in such facility, which are ordinarily furnished by the **Inpatient Rehabilitation** Facility for the care Treatment of a Confined person; and
   d. Charges for medical services of interns, in training, under a teaching program of a Hospital with which the facility has an agreement for such services

9. **Mental Health Disorder Benefit** for inpatient Treatment of Mental Health Disorders as specified on the Schedule of Benefits.

10. **Substance Use Disorder Benefit** for inpatient Treatment of Substance Use Disorders on the same basis as any other Covered Sickness as specified on the Schedule of Benefits.

Outpatient Benefits

1. **Outpatient Surgery including Surgeon, Anesthetist, and Assistant Surgeon Services** for outpatient surgery (including fees for pre- and post-operative visits) as specified in the Schedule of Benefits. Covered surgical expenses will be paid under either the outpatient surgery benefit or the inpatient Surgery Benefit. They will not be paid under both. This benefit is not payable in addition to Physician's visits.

   Sometimes 2 or more surgical procedures can be performed during the same operation.

   1. **Through the Same Incision.** If Covered multiple surgical procedures are performed through the same incision, We will pay for the procedure with the highest allowed amount and 50% of the amount We would otherwise pay under this Certificate for the secondary procedures, except for secondary procedures that, according to nationally-recognized coding rules, are exempt from multiple surgical procedure reductions. We will not pay anything for a secondary procedure that is billed with a primary procedure when that secondary procedure is incidental to the primary procedure.

   2. **Through Different Incisions.** If Covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay:
      - For the procedure with the highest allowed amount; and
      - 50% of the amount We would otherwise pay for the other procedures.

2. **Outpatient Surgical Facility and Miscellaneous** expense benefit. Benefits will be paid for services and supplies, including:
   a. Operating room;
   b. Therapeutic services;
   c. Oxygen, oxygen tent; and
   d. Blood and blood plasma.

3. **Physician's Office Visits**. We will not pay for more than 1 visit per day to the same Physician. Physician's Visits include second surgical opinions. Benefits will be paid for either outpatient or inpatient visits on the same day, but not both. Surgeon fees are NOT payable under this benefit.

4. **Specialist/Consultant Physician's Services.** When requested and approved by the attending Physician.

5. **Telemedicine or Telehealth Services** for health care delivery, diagnosis, consultation, Treatment, transfer of medical data, and education using interactive audio, video, or data communications involving a real time (synchronous) or near real time (asynchronous) 2-way transfer of medical data and information.

6. **Cardiac Rehabilitation.** Benefits are available for Outpatient cardiac rehabilitation programs. Covered Medical Expenses are: exercise and education under the direct supervision of skilled program personnel in the intensive rehabilitation phase of the program. The program must start within 3 months after a cardiac condition is diagnosed or a cardiac procedure is completed. The program must be completed within 6 months of the cardiac diagnosis or procedure.

   No benefits are available for portions of a cardiac rehabilitation program extending beyond the intensive rehabilitation phase. On-going or life-long exercise and education maintenance programs intended to maintain fitness or to reinforce permanent lifestyle changes are not covered.

7. **Pulmonary Rehabilitation.** Benefits are available for pulmonary rehabilitation services as part of an inpatient Hospital stay if it is part of a treatment plan ordered by a Physician. A course of outpatient pulmonary rehabilitation may also be eligible for coverage if it is performed at a Hospital, Skilled nursing facility, or Physician's office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by a Physician.

8. **Rehabilitative Therapy** when prescribed by the attending Physician, limited to 1 visit per day.

9. **Habilitative Services** when prescribed by the attending Physician, limited to 1 visit per day.

10. **Emergency Services** only in connection with care for an Emergency Medical Condition as defined. Payment of this benefit will not be denied based on the final diagnosis following stabilization.

11. **Urgent Care Centers** for services provided at an Urgent Care Center, as shown in the Schedule of Benefits.

12. **Diagnostic Imaging Services** for diagnostic X-ray services as shown in the Schedule of Benefits when prescribed by a Physician.

13. **CT Scan, MRI and/or PET Scans** for diagnostic services when prescribed by a Physician.

14. **Laboratory Procedures (Outpatient)** for laboratory procedures as shown in the Schedule of Benefits when prescribed by a Physician.

15. **Chemotherapy and Radiation Therapy** for chemotherapy, oral chemotherapy drugs, and radiation therapy to treat or control a serious illness, as shown in the Schedule of Benefits.

16. **Infusion Therapy** for the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

17. **Home Health Care Expenses** for Home Health Care for You when, otherwise, Hospitalization or Confinement in a Skilled Nursing Facility would have been necessary. This does not include Private Duty Nursing.

18. **Hospice Care Coverage** when, as the result of a Covered Injury or Covered Sickness, You require Hospice Care, we will pay the expenses incurred for such care. You must have been diagnosed with a terminal illness by a licensed Physician. Their medical prognosis must be death within 6 months. You must have elected to receive palliative rather than curative care. Any required documentation will be no greater than that required for the same services under Medicare.

19. **Outpatient Private Duty Nursing** services for non-hospitalized care performed by a R.N. or L.P.N for a Covered Injury or Covered Sickness if the condition requires skilled nursing care and visiting nursing care is not adequate. Services must be:
    - rendered in the home;
    - prescribed by the attending Physician as being medically necessary; and
    - performed by a certified Home Health Agency.

20. **Mental Health Disorder Benefit** for Outpatient Treatment of Mental Health Disorders as specified on the Schedule of Benefits.

21. **Substance Use Disorder Benefit** for Outpatient Treatment of Substance Use Disorders as specified on the Schedule of Benefits.

22. **Prescription Drugs** are medications filled in an outpatient pharmacy for which a Physician's written prescription is required up to the amount shown in the Schedule of Benefits. This benefit is limited to medication necessary for the Treatment of the Covered Injury or Covered Sickness for which a claim is made. Some outpatient prescription drugs are subject to pre-certification. These prescription requirements help Your prescriber and pharmacists check that Your outpatient prescription drug is clinically appropriate using evidence-based criteria.

    a. **Off-Label Drug Treatments** - When prescription drugs are provided as a benefit of the issued Certificate, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
        1. The drug is approved by the FDA;
        2. The drug is prescribed for the Treatment of a life-threatening condition, including cancer, HIV or AIDS;

3. The drug has been recognized for Treatment of that condition by 1 of the following: a) The American Medical Association Drug Evaluations; b) The American Hospital Formulary Service Drug Information; c) The United States Pharmacopoeia Dispensing Information, volume 1, "Drug Information for Health Care Professionals"; or d) 2 articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is a clear and convincing contradictory evidence presented in a major peer reviewed medical journal.
   When this portion of the prescription benefit is used, it will be the responsibility of the prescriber to submit to Us documentation supporting compliance with the requirements of this benefit.

As it pertains to this benefit, life threatening means either or both of the following:

a. Disease or conditions where the likelihood of death is high unless the course of the disease is interrupted; or
b. Disease or conditions with a potentially fatal outcome and where the end point of clinical intervention is survival.

b. **Dispense as Written (DAW)** – If a prescriber prescribes a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available and specifies: "Dispense as Written" (DAW), You will pay the cost sharing for the Brand-Name Prescription Drug. If a prescriber does not specify DAW and the Member requests a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available, the Member will be responsible for the cost difference between the Brand-Name Prescription Drug and the Generic Prescription Drug equivalent, and the cost sharing that applies to Brand-Name Prescription Drugs.

c. **Investigational Drugs and Medical Devices** – The Prescription Drug benefit includes a drug or device that is Investigational if the intended use of the drug or device is included in the labeling authorized by the FDA or if the use of the drug or device is recognized in one of the standard reference compendia or in peer-reviewed medical literature.

d. **Specialty Prescription Drugs** are limited to no more than a 30-day supply subject to supply limits. However, if the Specialty Prescription Drug dispensed is the smallest package size available and exceeds a 30-day supply, You are responsible for the cost sharing defined for the day supply in your schedule of benefits.

   Specialty Drugs – are Prescription Drugs which:
   1. Are only approved to treat limited patient populations, indications, or conditions; or
   2. Are normally injected, infused, or require close monitoring by a Physician or clinically trained individual; or
   3. Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

e. **Self-Administered Prescription Drugs** – Certain self-administered Prescription Drugs are only covered under the Prescription Drug benefit and are excluded from the medical benefit. Self-administered Prescription Drugs will not be covered when dispensed through a Physician's office or outpatient hospital, except in emergency situations. While members may self-administer these medications, they can still obtain these medications at the pharmacy and have them administered at an office visit. Coverage exceptions may be granted if self-administered Prescription Drugs are required as part of a hospitalization or emergency room visit. The list of self-administered Prescription Drugs only covered under the Prescription Drug benefit and excluded from the medical benefit can be found here: www.wellfleetstudent.com.

f. **Retail Pharmacy Supply Limits** – We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for 1 cost sharing amount for up to a 30-day supply. However, if the Prescription Drug dispensed is the smallest package size available and exceeds a 30-day supply, You are responsible for the cost sharing defined for the day supply in your Schedule of Benefits.

g. **Step Therapy** – When medications for the Treatment of any medical condition are restricted for use by a step

therapy or fail-first protocol, the prescribing practitioner shall have access to a clear and convenient process to request an override of the restriction from Us. An override of that restriction will be granted by Us upon completion of the review if all necessary information to perform the override review has been provided, under the following documented circumstances:

1. The prescribing practitioner can demonstrate, based on sound clinical evidence, that the preferred Treatment required under step therapy or fail-first protocol has been ineffective in the Treatment of Your disease or medical condition; or
2. Based on sound clinical evidence or medical and scientific evidence:
   a) The prescribing practitioner can demonstrate that the preferred Treatment required under the step therapy or fail-first protocol is expected or likely to be ineffective based on the known relevant physical or mental characteristics of the Insured and known characteristics of the drug regimen; or
   b) The prescribing practitioner can demonstrate that the preferred Treatment required under the step therapy or fail-first protocol will cause or will likely cause an adverse reaction or other physical harm to You.

h. **Quantity Limits** – Some Outpatient Prescription Drugs are subject to quantity limits. The quantity limits help the prescriber and pharmacist check that the Outpatient Prescription Drug is used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by Us to set these quantity limits.

i. **Tier Status** –You may access the most up to date tier status on Our website www.wellfleetstudent.com or by calling the number on Your ID card.

j. **Compounded Prescription Drugs** will be Covered only when they contain at least 1 ingredient that is a Covered legend Prescription Drug, do not contain bulk chemicals, and are obtained from a pharmacy that is approved for compounding. Compounded Prescription Drugs may require Your Provider to obtain Preauthorization. Compounded Prescription Drugs will be covered as the tier associated with the highest tier ingredient.

k. **Formulary Exception Process** – If a Prescription Drug is not on Our Formulary, You, Your Authorized Representative or Your prescribing Physician may request a Formulary exception for clinically appropriate Prescription Drug in writing, electronically or telephonically. If coverage is denied under Our standard or expedited Formulary exception process, the Covered Person is entitled to an external appeal as outlined in the External Appeal section of this Certificate. Refer to the Formulary posted on Our website www.wellfleetstudent.com or call the number on the Member's ID card to find out more about this process.

Standard Review of a Formulary Exception – We will make a decision and notify You or Your Authorized Representative and the prescribing Health Care Professional no later than 72 hours after Our receipt of the Member's request. If We approve the request, We will cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

Expedited Review of a Formulary Exception – If You are suffering from a health condition that may seriously jeopardize Your health, life or ability to regain maximum function or if You are undergoing a current course of Treatment using a Non-Formulary Prescription Drug, You may request an expedited review of a Formulary exception. The request should include a statement from Your prescribing Physician that harm could reasonably come to You if the requested drug is not provided within the timeframes for Our standard Formulary exception process. We will make a decision and notify You or Your Authorized Representative and the prescribing Physician no later than 24 hours after Our receipt of Your request. If We approve the request, We will cover the Prescription Drug.

l. **Tobacco cessation prescription and over-the-counter drugs** – Tobacco cessation prescription drugs and OTC drugs will be covered for two 90-day treatment regimens only. Any additional prescription drug treatment regimens will be subject to the cost sharing in Your schedule of benefits. For details on the current list of tobacco cessation prescription drugs and OTC drugs covered with no cost sharing during the two 90-day

treatment regimens allowed, refer to the Formulary posted on Our website www.wellfleetstudent.com or call 877-657-5030 .

m. **Zero Cost Generics** – In addition to ACA Preventive Care medications, certain Generic Drugs are covered at no cost to you. These zero cost generics can be identified in the Formulary posted on Our website www.wellfleetstudent.com .

n. **Preventive contraceptives** - For females who are able to reproduce, Your Outpatient Prescription Drug plan covers certain Prescription drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a Physician and the prescription is submitted to the pharmacist for processing. Your outpatient prescription drug plan also covers related services and supplies needed to administer covered devices. At least 1 form of contraception in each of the methods identified by the FDA is included. You can access the list of contraceptive prescription drugs by referring to the Formulary posted on Our website www.wellfleetstudent.com or calling the toll-free number on your ID card.

We cover over-the-counter (OTC) and **Generic Prescription Drugs** and devices for each of the methods identified by the FDA at no cost share. If a **Generic Prescription Drug** or device is not available for a certain method, You may obtain a certain **Brand-Name Prescription Drug** for that method at no cost share.

o. **Orally administered anti-cancer drugs, including chemotherapy drugs - Covered Medical Expenses** include any drug prescribed for the treatment of cancer if it is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication.

p. **Diabetic supplies**
The following diabetic supplies may be obtained under Your Prescription Drug benefit upon prescription by a Physician:
- Insulin
- Insulin syringes and needles
- Blood glucose test strips
- Lancets
- Alcohol swabs

You can access the list of diabetic supplies by referring to the Formulary posted on Our website www.wellfleetstudent.com or by calling the toll-free number on your ID card. See Your Diabetic services and supplies (including equipment and training) section for coverage of blood glucose meters and external insulin pumps.

q. **Preventive Care drugs and Supplements-** Covered Medical expenses include preventive care drugs and supplements (including over the counter drug and supplements as required by the Affordable Care Act (ACA) guidelines when prescribed by a Physician and the prescription is submitted to the pharmacist for processing.

Other Benefits

1. **Allergy Testing** this includes tests that You need such as PRIST, RAST, and scratch tests.

2. **Allergy Injections/Treatment** includes Treatment of anaphylaxis and angioedema, severe chronic sinusitis not responsive to medications and asthma not responding to usual Treatments. This also includes the administration of allergy therapy, injections, allergy serum, and supplies used for allergy therapy.

3. **Ambulance Service** for transportation to and from a Hospital by a licensed Ambulance whether a ground, air or water Ambulance, in a Medical Emergency. Transportation from a facility to your home is not covered.

Your plan also covers transportation to a Hospital by professional air or water Ambulance when:

- Professional ground Ambulance transportation is not available
- Your condition is unstable, and requires medical supervision and rapid transport
- You are travelling from one Hospital to another and
  - The first Hospital cannot provide the emergency services you need; and
  - The two (2) conditions above are met

4. **Covered Cancer Clinical Trials** for expenses incurred as a result of a Treatment being provided in accordance with a clinical trial for cancer, except any applicable Copayment, Deductible, or Coinsurance amounts.
   Costs of investigational Treatments and costs of associated protocol-related patient care shall be covered if all of the following criteria are met:
   a. The Treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention or early detection of cancer.
   b. The Treatment is being provided or the studies are being conducted in a Phase II, Phase III, or Phase IV clinical trial for cancer.
   c. The Treatment is being provided in accordance with a clinical trial approved by one of the following entities:
      (1) One of the United States NIH.
      (2) A cooperative group funded by one of the NIH.
      (3) The FDA in the form of an investigational new drug application.
      (4) The United States Department of Veteran Affairs. (5) The United States Department of Defense.
      (6) A federally funded general clinical research center.
      (7) The Coalition of National Cancer Cooperative Groups.
   d. The proposed protocol has been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks.
   e. The facility and personnel providing the protocol provided the Treatment within their scope of practice, experience,
   f. and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.
   g. There is no clearly superior, non-investigational approach.
   h. The available clinical or preclinical data provide a reasonable expectation that the Treatment will be at least as efficacious as the non-investigational alternative.
   i. The Insured Person has signed an institutional review board approved consent form.

5. **Durable Medical Equipment** for the rental or purchase of Durable Medical Equipment, including, but not limited to, Hospital beds, wheel chairs, walkers, braces that stabilize an injured body part and braces to treat curvature of the spine. We will pay the lesser of either the rental or purchase charges, but not both. Such equipment must be prescribed by a Physician and a copy of the written prescription must accompany the claim. Durable Medical Equipment must:
   a. Be primarily and customarily used to serve a medical, Rehabilitative purpose;
   b. Be able to withstand repeated use; and
   c. Generally, not be useful to a person in the absence of Injury or Sickness.

6. **Diabetic services and supplies (including equipment and training)** Benefits will be paid the same as any other Sickness for the cost associated with equipment, supplies, and self-management training and education for the treatment of all types of diabetes mellitus when prescribed by a Physician.

   Benefits includes services and supplies:
   - Insulin preparations
   - Foot care to minimize the risk of infection
   - Injection aids for the blind
   - Diabetic test agents
   - Prescribed oral medications whose primary purpose is to control blood sugar
   - Injectable glucagons
   - Glucagon emergency kits

Equipment

- External insulin pumps
- Blood glucose monitors without special features, unless required for the legally blind
- Podiatric appliances for the prevention of complications associated with diabetes

Training

- Self-management training
- Patient management materials that provide essential diabetes self-management information

"Self-management training" is a day care program of educational services and self-care designed to instruct You in the self-management of diabetes (including medical nutritional therapy). The training must be provided by an American Diabetes Association Recognized Diabetes Self-Management Education Program or Physician whose scope of practice includes diabetic education or management or a Registered Dietician.

1. A one-time evaluation and training program per Policy for diabetes self-management, not to exceed five hundred dollars ($500);
2. Additional diabetes self-management training will be limited to one hundred dollars ($100) per Policy Year and a lifetime of two thousand dollars ($2,000) per Insured Person.

This coverage includes the treatment of insulin (type I) and non-insulin dependent (type II) diabetes and the treatment of elevated blood glucose levels during pregnancy.

Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.

7. **Dialysis Treatment** of an acute or chronic kidney ailment, provided in an Outpatient facility of a Hospital, a free-standing renal Dialysis facility or in the home. Covered services for home Treatment will include equipment, training and medical supplies. Private Duty Nursing is not covered.

8. **Hearing Aids** for Insured Persons, if the hearing aids are fitted and dispensed by a licensed audiologist or licensed Hearing Aid specialist following medical clearance by a licensed Physician and an audiological evaluation that is medically appropriate. We will pay the expense incurred, every thirty-six (36) months.

   We will allow any Insured Person seeking coverage of a covered hearing aid the option to choose a hearing aid priced higher than the benefit payable under this plan. Any additional amounts owed shall be paid by the Insured Person.

   As used in this benefit:
   Hearing Aid means a non-disposable device that is of a design and circuitry to optimize audibility and listening skills.

9. **Maternity Benefit** for maternity charges as follows:
   a. Routine prenatal care

   b. **Hospital stays** for mother and newly born child will be provided for up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery unless the caesarean section delivery is the result of Complications of Pregnancy. If the delivery is the result of Complications of Pregnancy, the Hospital stay will be covered the same as for any other Covered Sickness. Services of a licensed nurse midwife are also covered.

      Services covered as inpatient care will include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.

   c. **Inpatient Physician charges or Surgeon charges** will be covered the same as for any other Covered Sickness for both mother and newborn child.

d. **Physician-directed Follow-up Care** including:
   1. Physician assessment of the mother and newborn;
   2. Parent education;
   3. Assistance and training in breast or bottle feeding;
   4. Assessment of the home support system;
   5. Performance of any prescribed clinical tests; and
   6. Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric obstetrical and nursing professionals.

   This benefit will apply to services provided in a medical setting or through Home Health Care visits. Any Home Health Care visit must be provided by an individual knowledgeable and experienced in maternity and newborn care. All Home Health Care visits that are made necessary by early discharge from the Hospital must be performed within 72 hours after discharge. When a mother or a newborn receives at least the number of hours of inpatient care shown in item "b", the Home Health Care visit benefit will apply to follow-up care that is determined to be necessary by the health care professionals responsible for discharging the mother or newborn.

e. **Outpatient Physician's visits** will be covered the same as for any other Covered Sickness.

f. **Routine Newborn Care** - when expenses are incurred for routine newborn care during the first 31 days immediately following the birth of an Insured Person, We will pay the expenses incurred not to exceed the benefit specified in the Schedule of Benefits. Such expenses include, but are not limited to:
   a. Charges made by a Hospital for routine well baby nursery care when there is a distinct charge separate from the charges for the mother;
   b. Inpatient Physician visits for routine examinations and evaluations;
   c. Charges made by a Physician in connection with a circumcision;
   d. Routine laboratory tests;
   e. Postpartum home visits prescribed for a newborn;
   f. Follow-up office visits for the newborn subsequent to discharge from a Hospital; and
   g. Transportation of the newborn to and from the nearest appropriately staffed and equipped facility for the Treatment of such newly born child.

10. **Enteral Formulas and Nutritional Supplements** Covered Medical expenses prescribed by a Physician used to treat malabsorption of food caused by:

- Crohn's Disease
- Ulcerative colitis
- Gastroesophageal reflux
- Gastrointestinal motility;
- Chronic intestinal pseudoobstruction
- Phenylketonuria
- Eosinophilic gastrointestinal disorders
- Inherited diseases of amino acids and organic acids
- Multiple severe food allergies
- Branded-chain ketonuria,
- Galactosemia
- Homocystinuria

Covered benefits also include food products modified to be low in protein for inherited diseases of amino acids and organic acids. For purposes of this benefit, "low protein modified food product" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a Physician for the dietary treatment of any inherited metabolic illness. Low protein modified food products do not include foods that are naturally low in protein.

11. **Prosthetic and Orthotic Devices** to replace all or part of a body organ, or replace all or part of the function of a permanently inoperative, absent, or malfunctioning body part when Medically Necessary and prescribed by a Physician.

    Prosthetic Devices and Services for Prosthetic Devices provided by an Accredited Facility and Prosthetic Services prescribed by a Physician and provided by an Accredited Facility.

    As used in this benefit:
    Accredited Facility means any entity that is accredited by the American Board for Certification in Orthotics Prosthetics and Pedorthics (ABC) or by the Board for Orthotist/Prosthetist Certification (BOC) and that provides Prosthetic Devices or Prosthetic Services.

    Prosthetic Devices means an artificial limb designed to maximize function, stability, and safety of the Insured Person. Prosthetic Device also means an artificial medical device that is not surgically implanted and that is used to replace a missing limb. The term does not include artificial eyes, ears, noses, dental appliances, ostomy products, or devices such as eyelashes or wigs.

    Prosthetic Services means the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing of a prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities to restore function, cosmesis, or both. It shall also include any Medically Necessary clinical care.

12. **Reconstructive Surgery** covers all stages of reconstruction of the breast on which the mastectomy has been performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance, including but not limited to liposuction performed for transfer to a reconstructed breast or to repair a donor site deformity, tattooing the areola of the breast, surgical adjustments to the non-mastectomized breast, and unforeseen medical complications which may require additional reconstruction in the future; and prostheses and physical complications for all stages of mastectomy, including lymphedemas. This benefit also covers cosmetic surgery specifically and solely for: Reconstruction due to bodily Injury, infection or other disease of the involved part; or for a congenital anomaly of a Dependent child which resulted in a functional impairment.

13. **Pediatric Dental Care Benefit** for the following dental care services for Insured Persons (to the end of the month in which the Insured Person turns age 19):
    a. Preventive dental care, that includes procedures which help to prevent oral disease from occurring, including:
        1. Dental examinations, visits and consultations once within a 6-month consecutive period (when primary teeth erupt);
        2. X-ray, full mouth x-rays at 36-month intervals, bitewing x-rays at 6 to 12-month intervals, or panoramic x-rays at 36-month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
        3. Prophylaxis (scaling and polishing the teeth) at 6-month intervals;
        4. Topical fluoride application at 6-month intervals where the local water supply is not fluoridated;
        5. Sealants on unrestored permanent molar teeth; and
        6. Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

    b. Emergency dental care, which includes emergency palliative treatment required to alleviate pain and suffering caused by dental disease or trauma.

    c. Routine Dental Care: We Cover routine dental care provided in the office of a Dental Provider, including:
        1. Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
        2. In-office conscious sedation;
        3. Amalgam, composite restorations and stainless-steel crowns; and
        4. Other restorative materials appropriate for children.

    d. Endodontic services, including procedures for Treatment of diseased pulp chambers and pulp canals, where

Hospitalization is not required.

e. Prosthodontic services as follows:
   1. Removable complete or partial dentures, including 6-months follow- up care; and
   2. Additional services include insertion of identification slips, repairs, relines and rebases and Treatment of cleft palate.

   Fixed bridges are not Covered unless they are required:
   1. For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth
   2. For cleft palate stabilization; or
   3. Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

f. Periodontic services include but are not limited to:
   1. root planning and scaling at 24-month intervals;
   2. gingivectomy at 36-month intervals;
   3. gingival flap procedures at 36-month intervals; and
   4. osseous surgery (including flap and closure) at 5 year intervals.

g. Orthodontics when Medically Necessary to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.
   Procedures include but are not limited to:
   1. Rapid Palatal Expansion (RPE);
   2. Placement of component parts (e.g. brackets, bands);
   3. Interceptive orthodontic Treatment;
   4. Comprehensive orthodontic Treatment (during which orthodontic appliances are placed for active Treatment and periodically adjusted);
   5. Removable appliance therapy; and
   6. Orthodontic retention (removal of appliances, construction and placement of retainers).

14. **Pediatric Vision Care Benefit** for Insured Persons (to the end of the month in which the Insured Person turns age 19).
    We will provide benefits for:
    a. 1 vision examination per Policy Year; and
    b. 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year.

15. **Accidental Injury Dental Treatment** as the result of Injury to sound natural teeth. Routine dental care and Treatment are not payable under this benefit. Damage to teeth due to chewing or biting is not deemed an accidental Injury and is not covered.

16. **Chiropractic Care Benefit** for Treatment of a Covered Injury or Covered Sickness and performed by a Physician.

17. **Organ, Tissue, and Bone Marrow Transplant Benefits** if a solid organ, tissue or bone marrow is obtained from a living donor for a covered transplant, the donor's medical expenses are covered as acquisition costs for the recipient under this Policy. Benefits for solid organ and bone marrow transplants are available only when services are rendered by a transplant center located in this state and the transplant center team is certified by the United Network for Organ Sharing and certified under Title XVIII of the Social Security Act or in the absence of such certification, other appropriate standards utilized by the majority of health insurance issuers in this state, unless otherwise approved by Us in writing. Benefits also include coverage for immunosuppressive drugs prescribed for transplant procedure(s) and high-dose chemotherapy to support transplant procedures.
    a. Solid human organ transplants of the: Liver; Heart; Lung; Kidney; Pancreas; Small bowel; and Other solid

organ transplant procedures, which We determine have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures.
These solid organ transplants will be considered on a case by case basis.

b. Tissue transplant procedures (autologous and allogeneic) as specified below: Tissue transplants (other than bone marrow) are covered and do not require prior authorization. However, if an Inpatient admission is required, it is subject to the Article on Care Management. The following tissue transplants are covered: Blood transfusions; Autologous parathyroid transplants; Corneal transplants; Bone and cartilage grafting; Skin grafting; Autologous islet cell transplants; and Other tissue transplant procedures which We determine have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These tissue transplants will be considered on a case by case basis.
c. Bone marrow transplants: Allogeneic, autologous and syngeneic bone marrow transplants, including tandem transplants, mini transplants (transplant lite) and donor lymphocyte infusions are covered.

The following exclusions apply to this benefit: Any costs of donating an organ or tissue for transplant when an Insured Person is a donor; the transplant of any non-human organ or tissue; or bone marrow transplants and stem cell rescue (autologous and allogeneic) are not covered, except as provided in this Policy. If any organ, tissue or bone marrow is sold rather than donated to an Insured Person, the purchase price of such organ, tissue or bone marrow is not covered.

Travel Expenses when the facility performing the Medically Necessary transplant is located more than 200 miles from Your residence, coverage will be provided for lodging, meals and transportation expenses (coach class only) subject to the maximum benefits shown on the Schedule of Benefits.

Non-Covered Services for transportation and lodging include, but are not limited to:
a. Child care;
b. Mileage within the medical transplant facility city;
c. Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us;
d. Frequent Flyer miles;
e. Coupons, Vouchers, or Travel tickets;
f. Prepayments or deposits;
g. Services for a condition that is not directly related or a direct result of the transplant;
h. Telephone calls;
i. Laundry;
j. Postage;
k. Entertainment;
l. Interim visits to a medical care facility while waiting for the actual transplant procedure;
m. Travel expenses for donor companion/caregiver;
n. Return visits for the donor for a Treatment of condition found during the evaluation.

18. **Shots and Injections** unless considered Preventive Services administered in an emergency room or Physician's office and charged on the emergency room or Physician's statement.

19. **Sports Accident Expense Benefit** for an Insured Student as the result of covered sports accident while at play or practice of intercollegiate sports as shown in the Schedule of Benefits.

20. **Non-emergency Care While Traveling Outside of the United States** for Medically Necessary treatment when You are traveling outside of the United States.

21. **Medical Evacuation Expense**
The maximum benefit for Medical Evacuation, if any, is shown in the Schedule of Benefits.

If:

a. You are unable to continue Your academic program as the result of a Covered Injury or Covered Sickness;
b. That occurs while You are covered under this Certificate,
We will pay the necessary Usual and Customary Charges for evacuation to another medical facility or Your Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

Payment of this benefit is subject to the following conditions:
a. You must have been in a Hospital due to a Covered Injury or Covered Sickness for a Confinement of 5 or more consecutive days immediately prior to medical evacuation;
b. Prior to the medical evacuation occurring, the attending Physician must have recommended and We must have approved the medical evacuation;
c. We must approve the Usual and Customary Expenses incurred prior to the medical evacuation occurring, if applicable;
d. No benefits are payable for Usual and Customary Expenses after the date Your insurance terminates. However, if on the date of termination, You are in the Hospital, this benefit continues in force until the earlier of the date the Confinement ends or 31 days after the date of termination;
e. Evacuation to Your Home Country terminates any further insurance under the Certificate for You; and
f. Transportation must be by the most direct and economical route.

22. **Repatriation Expense-**
The maximum benefit for Repatriation, if any, is shown in the Schedule of Benefits.
If You die while covered under this Certificate, We will pay a benefit. The benefit will be the necessary Usual and Customary Charges for preparation, including cremation, and transportation of the remains to Your place of residence Your Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

23. **Interpreter Services for the Deaf and Hard of Hearing** for services performed by a qualified interpreter/transliterator, other than a family member of the Insured Person, when such services are used by the Insured Person in connection with medical Treatment or diagnostic consultations performed by a Physician, provided the services are required because of a hearing impairment of the Insured Person or a failure of the Insured Person to understand or otherwise communicate in spoken language.

24. **Sleep Studies** for Medically Necessary sleep studies and associated professional claims are eligible for coverage when a sleep study is obtained in a facility that is accredited by the Joint Commission or the American Academy of Sleep Medicine (AASM).

25. **Lymphedema Benefit** for the Treatment of lymphedema, rendered or prescribed by a Physician or received in any Hospital or in any other public or private facility authorized to provide lymphedema Treatment. This includes multilayer compression bandaging systems and custom or standard-fit gradient compression garments.

26. **Oral Surgery Benefits** coverage is provided only for the following services or procedures:
a. Excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth;
b. Dental Care and Treatment including Surgery and dental appliances required to correct Accidental Injuries of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth, and of sound natural teeth. (For the purposes of this section, sound natural teeth include those which are capped, crowned or attached by way of a crown or cap to a bridge. Sound natural teeth may have fillings or a root canal.);
c. Excision of exostoses or tori of the jaws and hard palate;
d. Incision and drainage of abscess and treatment of cellulitis;
e. Incision of accessory sinuses, salivary glands, and salivary ducts;
f. Anesthesia for the above services or procedure when rendered by an oral surgeon;
g. Anesthesia for the above services or procedure when rendered by a dentist who holds all required permits or training to administer such anesthesia;
h. Anesthesia when rendered in a Hospital setting and for associated Hospital charges when a Member's mental or physical condition requires dental treatment to be rendered in a Hospital setting. Anesthesia benefits are not available for treatment rendered for Temporomandibular Joint (TMJ) Disorders;

Benefits are available for dental services not otherwise covered by this plan, when specifically required for head and neck cancer patients. Benefits are limited to preparation for or follow-up to radiation therapy involving the mouth.

Mandated Benefits for Louisiana

Mandate Disclaimer: If any Preventive Services Benefit is subject to the mandated benefits required by state law, they will be administered under the federal or state guideline, whichever is more favorable to the student.

Attention Deficit Disorder for the diagnosis and Treatment for attention deficit/hyperactivity disorder when rendered or prescribed by a Physician or other appropriate health care provider licensed in this state and received in any Physician's or other appropriate health care provider's office, any licensed Hospital, or in any other licensed public or private facility, including but not limited to clinics and mobile screening units. However, benefits for attention deficit/hyperactivity disorder provided for an initial diagnosis shall not exceed the amount shown in the schedule of benefits. Services rendered on an outpatient basis shall not exceed the amount shown in the schedule of benefits per visit with a Physician or other appropriate health care provider and total benefits shall be limited to the amount shown in the schedule of benefits during an Insured Person's lifetime, and shall not exceed the amount shown in the schedule of benefits in any given Policy Year.
Autism Spectrum Disorder for the diagnosis and Treatment of Autism Spectrum Disorders in individuals less than twenty-one (21) years of age.

As used in this benefit:
Autism Spectrum Disorder means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder not otherwise specified.

Bone Mass Measurement for a Qualified Individual for scientifically proven bone mass measurement for the diagnosis and Treatment of osteoporosis.

As used in this benefit:
Qualified Individual means an estrogen-deficient woman at clinical risk of osteoporosis who is considering Treatment; an individual receiving long-term steroid therapy; or an individual being monitored to assess the response to or efficacy of approved osteoporosis drug therapies.

Cancer Screening for the annual Pap test for cervical cancer, annual preventive cancer screening following a bilateral mastectomy, and the Minimum Mammography Examination when rendered or prescribed by a Physician or other appropriate health care provider in this state and received in any licensed Hospital or in any other licensed public or private facility, including but not limited to clinics and mobile screening units. We will also pay the expenses incurred for Routine Colorectal Cancer Screening and the detection of prostate cancer, including digital rectal examination and prostate-specific antigen testing for men over the age of fifty (50) years and as Medically Necessary and appropriate for men over the age of forty (40) years.

As used in this benefit:
Minimum Mammography Examination means mammographic examinations, including but not limited to digital breast tomosynthesis, performed no less frequently than the following schedule provides:

a. One baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age.
b. One mammogram every twenty-four months for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by her Physician.
c. One mammogram every twelve months for any woman who is fifty (50) years of age or older.

As used in this benefit:
Digital Breast Tomosynthesis means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

Routine Colorectal Cancer Screening means an annual FIT (Fecal Immunochemical Test for blood), or flexible

sigmoidoscopy every 5-10 years, or colonoscopy every 10 years beginning at age 50 (45 for African Americans) or CT colonography every 5 years or the FIT-fecal DNA test every 3 years or capsule colonoscopy every 5 years. As provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations. Routine Colorectal Cancer Screening shall not mean services otherwise excluded from coverage because they are deemed by a health coverage plan to be experimental or investigational.

Cleft Lip and Cleft Palate Coverage is provided for expenses incurred for the Treatment of cleft lip and cleft palate. Such coverage shall also include benefits for secondary conditions and Treatment attributable to that primary medical condition. Benefits include, but are not limited to:

a. Oral and facial surgery, surgical management, and follow-up care.
b. Prosthetic Treatment such as obturators, speech appliances, and feeding appliances.
c. Orthodontic Treatment and management.
d. Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic Treatment or prosthetic management or therapy.
e. Speech-language evaluation and therapy.
f. Audiological assessments and amplification devices.
g. Otolaryngology Treatment and management.
h. Psychological assessment and counseling.
i. Genetic assessment and counseling for Insured Person and parents.

Dental Anesthesia for anesthesia when rendered in a Hospital setting and for associated Hospital charges when the mental or physical condition of the Insured Person requires dental Treatment to be rendered in a hospital setting.

Outpatient Registered Dietician benefits are available for visits to a Registered Dietician.

SECTION V - ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If, as the result of a covered Accident, You sustain any of the following losses within the time shown in the Schedule of Benefits, We will pay the benefit shown.

Loss of Life	The Principal Sum
Loss of hand	One-Half the Principal Sum
Loss of Foot	One-Half the Principal Sum
Loss of either one hand, one foot or sight of one eye	One-half the Principal Sum
Loss of more than one of the above losses due to one Accident	The Principal Sum

Loss of hand or foot means the complete severance through or above the wrist or ankle joint. Loss of eye means the total permanent loss of sight in the eye. The Principal Sum is the largest amount payable under this benefit for all losses resulting from any one (1) Accident.

SECTION VI - EXCLUSIONS AND LIMITATIONS

Exclusion Disclaimer: Any exclusion in conflict with the Patient Protection and Affordable Care Act or any state imposed requirements will be administered to comply with the requirements of the federal or state guideline, whichever is more favorable to You.

The Certificate does not cover loss nor provide benefits for any of the following, except as otherwise provided by the benefits of the Certificate and as shown in the Schedule of Benefits.

1. **International Students Only** - Eligible expenses within Your Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which You could be eligible.
2. Treatment, service or supply which is not Medically Necessary for the diagnosis, care or treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended or approved by Your attending Physician or dentist.

3. Medical services rendered by a provider employed for or contracted with the Policyholder, including team physicians or trainers, except as specifically provided in the Schedule of Benefits.
4. Professional services rendered by an Immediate Family Member or anyone who lives with You.
5. Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary because of Injury, infection or disease.
6. Infertility treatment (male or female)-this includes but is not limited to:
   - Procreative counseling;
   - Premarital examinations;
   - Genetic counseling and genetic testing;
   - Impotence, organic or otherwise;
   - Injectable infertility medication, including but not limited to menotropins, hCG and GnRH agonists;
   - In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
   - Costs for an ovum donor or donor sperm;
   - Sperm storage costs;
   - Cryopreservation and storage of embryos;
   - Ovulation induction and monitoring;
   - Artificial insemination;
   - Hysteroscopy;
   - Laparoscopy;
   - Laparotomy;
   - Ovulation predictor kits;
   - Reversal of tubal ligations;
   - Reversal of vasectomies;
   - Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
   - Cloning; or
   - Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.
7. Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
8. Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services covered by Student Health Fees.
9. Any expenses in excess of Usual and Customary Charges except as provided in the Certificate.
10. Loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
11. Loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority.
12. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any club sports for which benefits are paid under another Sports Accident policy issued to the Policyholder; or for which coverage is provided by the National Collegiate Athletic Association (NCAA), National Association of Intercollegiate Athletic (NAIA) or any other sports association.
13. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
14. Treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which You are required to pay.
15. Services that are duplicated when provided by both a certified Nurse-midwife and a Physician.
16. Expenses payable under any prior policy which was in force for the person making the claim.
17. Injury sustained as the result of Your operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle accident takes place.
18. Expenses incurred after:
    - The date insurance terminates as to an Insured Person, except as specified in the extension of benefits provision; and

- The end of the Policy Year specified in the Policy.

19. Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
20. Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
21. Weight management. Weight reduction. Nutrition programs. This does not apply to nutritional counseling or any screening or assessment specifically provided under the Preventive Services benefit, or otherwise specifically covered under the Certificate.
22. Treatment for obesity. Surgery for removal of excess skin or fat.
23. Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
24. Expenses for radial keratotomy.
25. Adult Vision unless specifically provided in the Certificate.
26. Charges for office visit exam for the fitting of prescription contact lenses, duplicate spare eyeglasses, lenses or frames, non-prescription lenses or contact lenses that are for cosmetic purposes.
27. Charges for hearing exams, hearing screening, and the fitting or repair or replacement of hearing aids or cochlear implants except as specifically provided in the Certificate.
28. Racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are customarily used), ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles) or other hazardous sport or hobby.
29. Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma.
30. Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.
31. Extraction of impacted wisdom teeth or dental abscesses.
32. Treatment of Temporomandibular Joint Dysfunction (TMJ) other than a surgical procedure for those covered conditions affecting the upper or lower jawbone or associated bone joints. Such a procedure must be considered Medically Necessary based on the Certificate definition of same.
33. Elective abortions.
34. Custodial Care service and supplies.
35. Charges for hot or cold packs for personal use.
36. Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
37. Services of private duty Nurse except as provided in the Certificate.
38. Expenses that are not recommended and approved by a Physician.
39. Routine harvesting and storage of stem cells from newborn cord blood, the purchase price of any organ or tissue, donor services if the recipient is not an Insured Person under this plan, or services for or related to the transplantation of animal or artificial organs or tissues.
40. Cosmetic procedures related to Gender Reassignment including but not limited to rhinoplasty, face lift, facial bone reduction, lip enhancement or reduction, blepharoplasty, breast augmentation, body contouring, reduction thyroid chondroplasty, hair removal, voice modification surgery, skin resurfacing, chin implants, nose implants.
41. Sleep Disorders, except for the diagnosis and treatment of obstructive sleep apnea.
42. Treatment of Acne unless Medically Necessary.
43. Experimental or Investigational drugs, devices, treatments or procedures unless otherwise covered under Covered Clinical Trials or covered under clinical trials (routine patient costs). See the Other Benefits section for more information.
44. Under the Prescription Drug Benefit shown in the Schedule of Benefits:
    - any drug or medicine which does not, by federal or state law, require a prescription order, i.e. over-the-counter drugs, even if a prescription is written, except as specifically provided under Preventive Services or in the Prescription Drug Benefit section of this Certificate. Insulin and OTC preventive medications required under ACA are exempt from this exclusion;
    - drugs with over-the-counter equivalents except as specifically provided under Preventive Services;
    - allergy sera and extracts administered via injection;
    - any drug or medicine for the purpose of weight control;
    - fertility drugs;
    - sexual enhancements drugs;

- vitamins, and minerals, except as specifically provided under Preventive Services;
- food supplements, dietary supplements; except as specifically provided in the Certificate;
- cosmetic drugs or medicines, including but not limited to, products that improve the appearance of wrinkles or other skin blemishes;
- refills in excess of the number specified or dispensed after 1 year of date of the prescription;
- drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
- any drug or medicine purchased after coverage under the Certificate terminates;
- any drug or medicine consumed or administered at the place where it is dispensed;
- if the FDA determines that the drug is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason;
- bulk chemicals;
- non-insulin syringes, surgical supplies, durable medical equipment/medical devices, except as specifically provided in the Prescription Drug Benefit section of the Certificate;
- repackaged products;
- blood components except factors;
- immunology products.

45. Non-chemical addictions.
46. Non-physical, occupational, speech therapies (art, dance, etc.).
47. Modifications made to dwellings.
48. General fitness, exercise programs.
49. Hypnosis.
50. Rolfing.
51. Biofeedback.

Third Party Refund - When:

1. You are injured through the negligent act or omission of another person (the "third party"); and
2. benefits are paid under this Certificate as a result of that Injury,

We are entitled to a refund by You of all Certificate benefits paid as a result of the Injury.

The refund must be made to the extent that You receive payment for the Injury from the third party or that third party's insurance carrier. We may file a lien against that third-party payment. Reasonable pro rata charges, such as legal fees and court costs, may be deducted from the refund made to Us. You must complete and return the required forms to Us upon request.

COORDINATION OF BENEFITS

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one (1) Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

DEFINITIONS

1. A Plan is any of the following that provides benefits or services for medical or dental care or Treatment. If separate policies are used to provide coordinated coverage for members of a group, the separate policies are considered parts of the same plan and there is no COB among those separate policies.
   a. Plan includes: group and nongroup insurance policies, health maintenance organization ("HMO") policies, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care policies, such as skilled nursing care; medical benefits under group or individual automobile policies; and Medicare or any other federal governmental plan, as permitted by law.

b. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each Certificate for coverage under a. or b. is a separate Plan. If a Plan has 2 parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

2. This plan means, in a COB provision, the part of the Certificate providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the Certificate providing health care benefits is separate from this plan. A Certificate may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

3. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

   When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

4. Allowable expense is a health care service or expense, including Deductibles, Coinsurance and Copayments, that is covered in full or at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging You is not an Allowable expense.

   The following are examples of expenses that are not Allowable expenses:
   a. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
   b. If a person is covered by two or more Plans that compute their benefit payments on the basis of Usual and Customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
   c. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
   d. If a person is covered by one Plan that calculates its benefits or services on the basis of Usual and Customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's Policy permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
   e. The amount of any benefit reduction by the Primary plan because You failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, Pre-Certification of admissions, and preferred provider arrangements.

5. Closed panel plan is a Plan that provides health care benefits to Insured Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

6. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

(1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the Policyholder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network Provider benefits.

B. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

C. Each Plan determines its order of benefits using the first of the following rules that apply:
(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, Policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two (2) Plans is reversed so that the Plan covering the person as an employee, member, Policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
(2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.
(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
i. If a court decree states that one (1) of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
iii. If a court decree states that the parents have joint custody without specifying that 1 parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
• The Plan covering the Custodial parent;
• The Plan covering the spouse of the Custodial parent;
• The Plan covering the non-custodial parent; and then
• The Plan covering the spouse of the non-custodial parent.
(c) For a dependent child covered under more than one Plan of individuals who are <u>not</u> the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
(d) a. For a dependent child who has coverage under either or both parents' plans and also has his or her own

coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

b. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

(3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, Policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

B. If an Insured Person is enrolled in 2 or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by 1 Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

C. Effect on the Benefits of This Plan

1. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year or claim determination period are not more than 100 percent of total Allowable expenses. The difference between the benefit payments that this Plan would have paid had it been the Primary Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Insured and used by this Plan to pay any Allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, This Plan will:
   a. determine its obligation to pay or provide benefits under its contract;
   b. determine whether a benefit reserve has been recorded for the Insured; and
   c. determine whether there are any unpaid Allowable Expenses during that claims determination period.
2. If there is a benefit reserve, the Secondary Plan will use the Insureds benefit reserve to pay up to 100 percent of total Allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. Our Agent or We may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. Our Agent or We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give Our Agent or We any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, Our Agent or We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. Our Agent or We will not have to pay that amount again. The term payment made includes providing benefits in the form of services, in which case payment made means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Our Agent or We is more than it should have paid under this COB provision, it may recover the excess from one (1) or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Insured Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION OF BENEFITS - IMPORTANT NOTICE

This is a summary of only a few of the provisions of the health plan to help the Insured understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in this Certificate, which determines the Insureds benefits.

Double Coverage

It is common for Dependents to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.
When an Insured is covered by more than one health plan, state law permits insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when an Insured has a claim. The goal is to make sure that the combined payments of all plans do not add up to more than the Insureds covered health care expenses. Coordination of benefits (COB) is complicated and covers a wide variety of circumstances. This is only an outline of some of the most common ones. Read this Certificate or contact your state insurance department.

Primary or Secondary?

The Insured will be asked to identify all the plans that cover Dependents. We need this information to determine whether We are the "primary" or "secondary" benefit payer. The Primary Plan always pays first when the Insured has a claim.

Any Plan that does not contain the state's COB rules will always be primary.

When This Plan is Primary

If the Insured or a Dependent is covered under another Plan in addition to this one, We will be primary for:

- The Insureds own health care expenses
- The Insureds Spouse's Expenses
- The Insureds Dependent Child's Expenses
- The claim is for the health care expenses of the Insureds child who is a Dependent under This Plan and the Insured is married and the Insureds birthday is earlier in the year than the Insureds spouse's or the Insured is living with another individual, regardless of whether or not the Insured has ever been married to that individual, and the Insureds birthday is earlier than that other individual's birthday. This is known as the "birthday rule"; or

- The Insured is separated or divorced and We have been informed of a court decree that makes the Insured responsible for the Dependent child's health care expenses; or
- There is no court decree, but the Insured has custody of the Dependent child.

Other Situations
We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary
When We are the Primary Plan, We will pay the benefits in accordance with the terms of the Insureds contract, just as if the Insured had no other health care coverage under any other Plan.

How We Pay Claims When We Are Secondary
We will be secondary whenever the rules do not require us to be primary.

When We are the Secondary Plan, We do not pay until after the Primary Plan has paid its benefits. We will then pay part or all of the Allowable expenses left unpaid, as explained below. An Allowable expense is a health care service or expense covered by one of the Plans, including Copays, Coinsurance and Deductibles.

- If there is a difference between the amount the Plans allow, We will base Our payment on the higher amount. However, if the Primary Plan has a contract with the provider, Our combined payments will not be more than the contract calls for. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) usually have contracts with their providers.
- We will determine Our payment by subtracting the amount the Primary Plan paid from the amount We would have paid if we had been primary.
- We will use any savings to pay the balance of any unpaid Allowable expenses covered by either Plan.
- If the Primary Plan covers similar kinds of health care expenses, but allows expenses that We do not cover, We will pay for those items as long as there is a balance in the Insureds benefit reserve, as explained below.
- We will not pay an amount the Primary Plan did not cover because the Insured did not follow its rules and procedures. For example, if the Insureds Plan has reduced its benefit because the Insured did not obtain pre-certification, as required by that Plan, we will not pay the amount of the reduction, because it is not an Allowable expense.
- Benefit Reserve
- When We are secondary, We often will pay less than We would have paid if we had been primary. Each time We "save" by paying less, We will put that savings into a benefit reserve. Each Dependent covered by This Plan has a separate benefit reserve. We use the benefit reserve to pay Allowable expenses that are covered only partially by both Plans. To obtain a reimbursement, the Insured must show Us what the Primary Plan has paid so We can calculate the savings.
- To make sure the Insured receives the full benefit or coordination, the Insured should submit all claims to each Plan. Savings can build up in the Insureds reserve for one year. At the end of the year any balance is erased, and a fresh benefit reserve begins for each Insured the next year as soon as there are savings on their claims.

Questions about Coordination of Benefits?
Contact the State of Louisiana's Insurance Department

Notice to Insured
If an Insured is covered by more than one Plan, claims should be filed with each Plan.
Additionally, an Insured may request a paper or electronic version of the "Explanation for Secondary Plans on the Purpose and Use of the Benefit Reserve and How Secondary Plans Calculate Claims" notice. To request a copy of this notice, please contact Us.

This notice is also available on the Louisiana Department of Insurance's website.

SECTION VII - GENERAL PROVISIONS

Entire Contract Changes: The Policy, this Certificate, including the application, endorsements and attached papers, if

any, constitutes the entire contract of insurance. No change in this Policy or Certificate will be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon. No agent has authority to change this Policy or Certificate or waive any of its provisions.

Reinstatement: If default is made in the payment of any agreed premium for this Policy, the subsequent acceptance of the defaulted premium by Us or by any agent authorized by Us to accept such premium, shall reinstate the Policy; however, the reinstated Policy shall cover only loss resulting from accidental injury thereafter sustained or loss due to Sickness beginning more than ten days after the date of such acceptance.

Notice of Claim: Written or electronic notice of a claim must be given to Us within 90 days after the date of Injury or commencement of Sickness covered by this Certificate, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to Our authorized agent, with information sufficient to identify You will be deemed notice to Us.

Claim Forms: We, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by Us for filing proofs of loss. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limits stated in the Proofs of Loss provision.

Uniform Claim Forms: All claims shall be processed in conformity with the uniform claim form issued by the Department of Insurance pursuant to R.S. 22:1824.

Proof of Loss: Written proof of Loss must be furnished to Us or to our authorized agent within 90 days after the date of such Loss. If it was not reasonably possible to give written proof in the time required, We may not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. The proof required must be given no later than one (1) year from the time specified unless the claimant was legally incapacitated.

Time of Payment: Indemnities payable under this Certificate will be paid immediately upon receipt of due proof of such Loss.

Payment of Claims: Benefits will be paid to You. Loss of life benefits, if any, will be payable in accordance with the beneficiary designation in effect at the time of payment. If no such designation or provision is then effective, the benefits will be payable to Your estate. Any other accrued indemnities unpaid at the time of Your death may, at Our option, be paid either to such beneficiary or to such estate.

If benefits are payable to Your estate or to a beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity, up to an amount not exceeding $1,000.00, to any one relative by blood or connection by marriage to You who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment.

We may pay all or a portion of any indemnities provided for health care services to the provider, unless You direct otherwise, in writing, by the time proofs of loss are filed. We cannot require that the services be rendered by a particular provider.

Consent of Beneficiary: Consent of the beneficiary shall not be required for the surrender or assignment of this Policy, nor for change of beneficiary, nor for any other changes in this Policy.

Assignment: The Insured Person may assign Out-of-Network benefits payable under this Certificate. In-network benefits are billed directly by the provider. We are not bound by an assignment unless it is in writing and until a duplicate of the original assignment has been filed with Us. We assume no responsibility regarding the validity of any assignment or payment made without notice of a prior assignment.

Physical Examination and Autopsy: We, at Our own expense, will have the right and opportunity to examine the person of an individual whose Injury or Sickness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim hereunder. In the case of Your death, We may have an autopsy performed unless prohibited by law.

Legal Actions: No action at law or in equity will be brought to recover on this Certificate prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Certificate. No such action will be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Time Limit on Certain Defenses: After three years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by the applicant in the application of such Policy shall be used to void the Policy or deny a claim for loss incurred or disability, as defined in the Policy, commencing after the expiration of such three-year period.

Conformity with State Statutes: Any provision of this Certificate which, on its Effective Date, is in conflict with the statutes of the state in which this Certificate was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statutes.

SECTION VIII - ADDITIONAL PROVISIONS

1. We do not assume any responsibility for the validity of assignment.

2. You will have free choice of a legally qualified Physician with the understanding that the Physician-patient relationship will be maintained.

3. Our acknowledgment of the receipt of notice given under this Certificate, or the furnishing of forms for filing proofs of loss or acceptance of such proof, or the investigation of any claim hereunder will not operate as a waiver of any of Our rights in defense of any claim arising under this Certificate.

4. This Certificate is not in lieu of and does not affect any requirement of coverage by Workers' Compensation Insurance.

5. All new persons in the groups or classes eligible to and applying for this insurance will be added in the respective groups or classes in which they are eligible.

6. The insurance of any Insured Person will not be prejudiced by the failure on the part of the Policyholder to transmit reports, pay premium or comply with any of the provisions of this Certificate when such failure is due to inadvertent error or clerical mistake.

7. All books and records of the Policyholder containing information pertinent to this insurance will be open to examination by Us during the Certificate term and within one year after the termination of this Certificate.

8. Benefits are payable under this Certificate only for those expenses incurred while you are covered. No benefits are payable for expenses incurred after the date Your insurance terminates, except as may be provided under an Extension of Benefits.

SECTION IX – APPEALS PROCEDURE

If You have a claim that is denied by Us, You have the right to appeal it. Your Authorized Representative may act on Your behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination.

For purposes of this Section, the following definitions apply:
Adverse Benefit Determination means:

- A determination by Us or Our designee Utilization review organization that, based upon the information provided, a request for a benefit under the Policy upon application of any utilization review technique does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be Experimental or Investigative and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;
- The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by Us or Our designee Utilization review organization of Your eligibility under the Policy;

- Any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit; or
- A rescission of coverage.

Authorized Representative means:
- A person to whom have given express written consent to represent You;
- A person authorized by law to provide substituted consent for You;
- A family member of Yours or Your treating health care professional when You are unable to provide consent;
- A health care professional when the Policy requires that a request for a benefit under the Policy be initiated by the health care professional; or
- In the case of an Urgent Care claim, a health care professional with knowledge of Your medical condition.

Concurrent claim means a request for a plan benefit(s) by You that is for an ongoing course of treatment or services over a period of time or for the number of treatments.

Concurrent review means Utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional or other inpatient or outpatient health care setting.

Health care professional means a Physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

Pre-service claim means the request for a plan benefit(s) by You prior to a service being rendered and is not considered a concurrent claim.

Post-Service Claim means any claims for a plan benefit(s) that is not a Pre-Service Claim.

Prospective review means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with Our requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

Retrospective review means any review of a request for a benefit that is not a prospective review request. Retrospective review does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

Urgent Care request means a request for a health care service or course of Treatment with respect to which the time periods for making a non-urgent care request determination:

1.
   (a) Could seriously jeopardize Your life or health or Your ability to regain maximum function; or
   (b) In the opinion of a Physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the health care service or Treatment that is the subject of the request.

2.
   (a) Except as provided in (b) of this paragraph, in determining whether a request is to be treated as an Urgent Care request, an individual acting on Our behalf shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
   (b) Any request that a Physician with knowledge of Your medical condition determines is an Urgent Care Request shall be treated as an urgent care request.

Utilization review means a set of formal techniques designed to monitor the use of, or evaluate the Medical Necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, Prospective review, second opinion, certification, Concurrent review, case management, discharge planning or Retrospective review.

Utilization review organization means an entity that conducts Utilization review, other than Us performing utilization review for Our own health benefit plans.

There are 3 types of claims: Pre-Service, Concurrent Care, and Post-Service Claims. In addition, certain Pre-Service or Concurrent Care Claims may involve Urgent Care. If the Company makes an Adverse Benefit Determination, then You may appeal according to the following steps.

Step 1:

If Your claim is denied, You will receive written notice from Us that Your claim is denied (in the case of Urgent Claims, notice may be oral). The period in which You will receive this notice will vary depending on the type of claim. In addition, We may take an extension of time in which to review Your claim for reasons beyond Our control. If the reason for the extension is that You need to provide additional information, You will be given a certain amount of time in which to obtain the requested information (it will vary depending on the type of claim). The period during which We must make a decision will be suspended until the earlier of the date that You provide the information or the end of the applicable information-gathering period.

Type of Claim	**You will be notified by Us that a claim is denied as soon as possible but no later than:**	**Extension period allowed for circumstances beyond Our control:**	**If additional information is needed, You must provide within:**
Pre-Service Claim	15 days from receipt of claim (whether adverse or not)	One extension of 15 days	45 days of date of extension notice
Pre-Service Claim involving Urgent Care	72 hours from receipt of claim (whether adverse or not) (24 hours after receipt of claim if additional information is needed from You)	None	48 hours (We must notify You of determination within 48 hours of receipt of Your information)
Concurrent: To end or reduce Treatment prematurely (other than by policy amendment or termination) Pending the outcome of an appeal, benefits for an ongoing course of Treatment will not be reduced or terminated.	Notification to end or reduce Treatment will allow sufficient time in advance to allow You to appeal and obtain a determination on the adverse benefit determination prior to the end or reduction of prescribed Treatment	N/A	N/A
Concurrent: To deny Your request to extend Treatment	30 days from receipt of claim for Pre-Service Claim; or 60 days from receipt of claim for Post-Service Claim	On extension of 15 days	45 days of the date of extension notice
Concurrent: Involving Urgent Care	72 hours from receipt of claim (whether adverse or not) (24 hours after receipt of claim if	None	48 hours (We must notify You of determination within 48 hours of receipt of Your information)

	additional information is needed from You; or 24 hours after receipt of claim provided that any such claim is made at least 24 hours prior to the end or reduction of prescribed Treatment)		
Post-Service Claim	30 days from receipt of claim	One extension of 15 days	45 days of the date of extension notice

Once You have received notice from Us, You should review it carefully. The notice will contain:

1. The reason(s) for the denial and the Policy provisions on which the denial is based.
2. A description of any additional information necessary for You to perfect Your claim, why the information is necessary, and Your time limit for submitting the information.
3. A description of the Policy's appeal procedures and the time limits applicable to such procedures, including a statement of Your right to bring a civil action following a final denial of Your appeal.
4. A statement indicating whether an internal rule, guideline or protocol was relied upon in making the denial and a statement that a copy of that rule, guideline or protocol will be made available upon request free of charge.
5. If the denial is based on a Medical Necessity, experimental Treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request; and
6. If the claim was an Urgent Care request, a description of the expedited appeals process. The notice may be provided to You orally within 72 hours; however, a written or electronic notification will be sent to You no later than 3 days after the oral notification. If the claim was/is an Urgent Care request, You may initiate an Internal Appeal and an External Review simultaneously.
7. Information sufficient to identify the claim (including the date of service, the health care provider, and the claim amount (if applicable).
8. An explanation of how to request diagnosis and treatment codes (and their corresponding meanings).
9. The contact information for all relevant review agency contacts and the office of health insurance consumer assistance to assist You with Your claims, appeals and external review.
10. Notification that culturally and linguistically appropriate services are available.

INTERNAL APPEAL

Step 2:

If You do not agree with Our decision and wish to appeal, You must file a written appeal with Us at the address below within 180 days of receipt of the notification (or oral notice if an Urgent Care request) referenced in Step 1. If the claim involves Urgent Care, Your appeal may be made orally.

You should submit all information referenced in Step 2 with Your appeal. You should gather any additional information that is identified in the notice as necessary to perfect Your claim and any other information that You believe will support Your claim.

Appeals should be sent to:
Commercial Casualty Insurance Company
Attention: Appeals Unit
Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369

Type of Claim	**You must file Your appeal**	**You will be notified of Our determination as**

	within:	soon as possible but no later than:
Pre-Service Claim	180 days of claim denial	30 days of receipt of appeal
Pre-Service Claim involving Urgent Care	180 days of claim denial	72 hours of receipt of appeal
Concurrent: To end or reduce Treatment prematurely	Notification will specify filing limit. Notification to end or reduce Treatment will allow sufficient time to finalize appeal before end of Treatment	15 days of receipt of appeal
Concurrent: To deny Your request to extend Treatment	180 days of claim denial for Pre-Service or Post-Service Claim	15 days of receipt of appeal for Pre-Service Claim; or 30 days of receipt of appeal for Post-Service Claim
Concurrent: Involving Urgent Care	180 days of claim denial	72 hours of receipt of appeal
Post-Service Claim	180 days of claim denial	60 days of receipt of appeal

Step 3:

If Your appeal is denied based on medical judgement such as Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or Treatment and You wish to seek an external review from an Independent Review Organization (IRO), You must file a written request for external review.

You may also seek an external review by an IRO for a denial of an Urgent Care request based on medical judgement provided that (1) You have also filed an internal appeal in accordance with the terms described herein; and (2) the time frames for completion of an Urgent Care appeal will seriously jeopardize Your life or health or would seriously jeopardize Your ability to regain maximum function.

You may also seek an external review for a rescission of coverage.

STANDARD EXTERNAL REVIEW

Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination, You may file a request for an external review with Us or the Louisiana Commissioner of Insurance.

You must file Your written request for an external review with Us at the address below within 4 months of the date You received the applicable denial.

Within 5 business days of receiving Your request for an external review, We will complete a preliminary review of the request to determine whether You were covered under the Policy at the time the expense was incurred and whether You have exhausted the Internal Appeal process where required.

In most cases, You should complete Our Internal Appeals process before You:

- Contact the Louisiana Department of Insurance to request an investigation of a claim determination or appeal;
- File a complaint or appeal with the Louisiana Department of Insurance;
- File a request for an External Review;
- Pursue arbitration, litigation or other type of administrative proceedings.

However, in some cases, You do not have to exhaust the Internal Appeal process before You move on to an External Review. These situations are:

- We waive the Internal Appeal process;
- You have an Urgent Care situation or a claim that involves ongoing treatment. In these situations, You may have Your claim go through the External Review at the same time as the Internal Appeal process; and
- We did not follow all of the State or Federal claim determination and appeal requirements. However, You will not be able to proceed directly to an External Review if:
    - The rule violation was minor and not likely to influence a decision or harm You;
    - The violation was for a good cause or a matter beyond Our control;
    - The violation was part of an ongoing good faith exchange of information between You and Us.

Within 1 business day of making a determination, You will be notified if the external review request is denied and You will be provided with: (1) the reasons why the claim is initially ineligible for external review; or (2) the information or materials needed for a complete request. In the event Your request is denied due to lack of information or materials, You must perfect Your claim by the later of the end of the 4-month period following the final internal Adverse Benefit Determination or 48 hours following notification that Your request for external review was denied.

If initially eligible for an external review, We will assign the request to an IRO. The IRO will make a determination and provide You and Us with notice of its determination within 45 days of receiving the review request.

EXPEDITED EXTERNAL REVIEW

If, due to Your medical condition, the time frame for completion of the standard external review process would seriously jeopardize Your life or health or Your ability to regain maximum function, You may request an expedited external review, the preliminary review will be completed immediately. If determined to be initially eligible, We will assign the request to an IRO and the IRO will complete the review as expeditiously as Your medical condition requires, but in no event more than 72 hours after receiving the request. If the notice is provided to You orally, a written or electronic notification will be sent to You no later than 48 hours after the oral notification.

IMPORTANT INFORMATION

- Each level of appeal will be independent from the previous level (i.e., the same person(s) involved in a prior level of appeal will not be involved in the appeal).
- The claims reviewer will review relevant information that You submit even if it is new information. In addition, You have the right to request documents or other records relevant to Your claim.
- If a claim involves medical judgement, then the claims reviewer will consult with an independent health care professional that has expertise in the specific area involving medical judgment.
- You may review the claim file and present evidence and testimony at each state of the appeals process.
- You may request, free of charge, any new or additional evidence considered, relied upon, or generated by Us in connection with Your claim.
- If a decision is made based on new or additional rationale, You will be provided with the rationale and be given a reasonable opportunity to respond before a final decision is made.
- If You wish to submit relevant documentation to be considered in reviewing Your claim for appeal, it must be submitted with Your claim and/or appeal.
- You should exhaust these appeals procedures before filing a complaint or appeal with the Louisiana Department of Insurance.
- You should raise all issues that You wish to appeal during Our Internal Appeal process and during the External Review.

CONTACT INFORMATION

If you have any questions or concerns, You can contact Us at:
Commercial Casualty Insurance Company
Attention: Appeals Unit
Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369

Louisiana
Department of Insurance
P.O. Box 94214
Baton Rouge, LA 70804-9214
(225) 342-5900
(800)259-5300

HIPAA Notice of Privacy Practices

of

COMMERCIAL CASUALTY INSURANCE COMPANY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

Effective: June 01, 2017

This Notice of Privacy Practices (" Notice") applies to Commercial Casualty Insurance Company's (" we", "us" or " our") insured health benefits plan. We are required to provide you with this Notice.

Personal Information is information that identifies you as an individual, such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic, and that we obtain so we can provide you with insurance coverage.

Protected Health Information (your "Health Information") is information that identifies you as related to your physical or mental health, your health care, or payment for your healthcare.

Our Responsibilities

We are required by law to maintain the privacy of the Health Information we hold and to provide you with this Notice and to follow the duties and privacy practices described in this Notice. We are required to abide by the terms of this Notice currently in effect.

We utilize administrative, technical, and physical safeguards to protect your information against unauthorized access and against threats and hazards to its security and integrity. We comply with all applicable state and federal rules pertaining to the security and confidentiality of your information.

We will promptly inform you if a breach has occurred that may have compromised the privacy or security of your Health Information.

Overview of this Notice

This Notice describes how certain information about you may be used and disclosed and how you can get access to this information. This Notice addresses three primary areas:

- An overview of Your Health Information. This section addresses how we collect your information, how we use it to run our business, and the reasons we share it.
- Your Rights. This section gives an overview of the rights you have with respect to your information we have in our records.
- How to Contact Us. In case you have any questions, requests, or even if you feel you need to make a complaint, we want to make sure you are in contact with the right person.

YOUR HEALTH INFORMATION

How We Acquire Your Information

In order to provide you with insurance coverage, we need Personal Information about you. Some of this information is collected from the school during the enrollment period. Other information comes to us from your health care provider, other insurers, third party administrators (TPAs), and your school's health center. This information is necessary to properly administer your health plan benefits.

How We use Your Health Information

Below are some examples of how we use and disclose your Health Information. Broadly, we will use and disclose your Health Information for Treatment, Payment and Health Care Operations.

Treatment refers to the health care treatment you receive. We do not provide treatment, but we may disclose certain information to doctors, dentists, pharmacies, hospitals, and other health care providers who will take care of you. For example, a doctor may send us information about your diagnosis and treatment so we can develop a health care plan and arrange additional services.

Payment refers to activities involving the collection of premiums, payment of claims, and determining covered services. For example, we may review your Health Information to determine if a particular treatment is medically necessary and what that payment for the services should be.

Health Care Operations refers to the business functions necessary for us to operate, such as audits, complaints responses and quality assurance activities. For example, we would use your Health Information (but not genetic information) for underwriting and calculating rates, or we may use your Health Information to detect and investigate fraud.

Additionally:

- We may **confirm enrollment** in this health plan with your school or to your school's consultant or your school's business partner.
- If you are a **dependent** of someone on the plan, we may disclose certain information to the plan's subscriber, such as an explanation of benefits for a service you may have received.
- Your school's health center may require enrollment information, payment information, or may require your Health Information to coordinate on-campus services you may need.

We may disclose your information when instructed to do so, including:

- **Health oversight activities** may require that we disclose your information to governmental, licensing, auditing and accrediting agencies;
- **Legal proceedings** may require disclosure of your Health Information in response to a court order or administrative order, or in response to a subpoena, discovery request, warrant, summons, or other valid process;
- **Law enforcement activities** might require disclosure of certain Health Information to local, state or federal law enforcement, so long as the release is authorized or required by law;
- **As required by law** or to avert a serious threat to safety or health; and,
- To **certain government agencies**, such as the Department of health and Human Services or the Office of Civil Rights if they are conducting an investigation or audit.

Authorizations

Occasionally we may receive a request to share your information in a manner outside of how we normally use your Health Information, as described above. In those cases, we will ask you for your authorization before we share your Health Information.

YOUR RIGHTS

You have the **right to request restrictions** on certain uses and disclosures of your Health Information, including the uses and disclosures listed in this Notice and disclosures permitted by law. You also have the **right to request that we communicate with you in certain ways**.

- We will accommodate reasonable requests;
- We are not required to agree to a request to restrict a disclosure unless you have paid for the cost of the health care item or service in full (i.e., the entire sum for the procedure performed) and disclosure is not otherwise required by law; and,
- If you are a minor, depending on the state you reside in, you may have the right in certain circumstances to block parental access to your Health Information. For example, a minor would have the rights of an adult with respect to diagnosis and care of conditions such as STDs, drug dependency, and pregnancy.

You have the **right to inspect and copy your Health Information** in our records. Please note that there are exceptions to this, such as:

- Psychotherapy notes;
- Information complied in reasonable anticipation, or for use in, a civil, criminal or administrative action or proceeding;
- Health Information that is subject to a law prohibiting access to that information; or,
- If the Health Information was obtained from someone other than us under a promise of confidentiality and the access request would be reasonably likely to reveal the source of the information.

We may deny your request to inspect and copy your Health Information if:

- A licensed health care professional has determined your requested access is reasonably likely to endanger your life or physical safety of another;
- The Health Information makes reference to another person and a licensed health care professional has determined that access requested is reasonably likely to cause substantial harm to another; or,
- A licensed health care professional has determined that access requested by your personal representative is likely to cause substantial harm to you or another person.

You have the **right to request an amendment** to your Health Information if you believe the information we have on file is incomplete or inaccurate. Your request must be in writing and must include the reason for the request. If we deny your request, you may file a written statement of disagreement.

You have the right to know who we have provided your information to - - this is known as an **accounting of disclosures**. A request for an accounting of disclosures must be submitted in writing to the address below. The accounting will not include disclosures made for treatment, payment, health care operations, for law enforcement purposes, or as otherwise permitted or required by law. If you request an accounting of disclosures more than once in a twelve (12) month period we may charge a reasonable fee to process, compile and deliver the information to you this second time.

You have a **right to receive a paper copy of this Notice.** Simply call the customer service line indicated on your ID card and request a paper copy be mailed to you. You may also submit a written request to us at the address below.

You will receive a notice of a breach of your Health Information. You have the **right to be notified of a breach** of unsecure Health Information.

Finally, you have the **right to file a complaint** if you feel your privacy rights were violated. You may also file a complaint with the Secretary of Health and Human Services.

CONTACT

For all inquiries, requests and complaints, please contact:

Privacy and Security Officer
Commercial Casualty Insurance Company
c/o Wellfleet Group, LLC
PO Box 15369
Springfield, MA
01115-5369

In California
c/o Wellfleet Group, LLC dba Wellfleet
Administrators, LLC
PO Box 15369
Springfield, MA 01115-5369

This Notice is Subject to Change

We may change the terms of this notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all of your Health Information we maintain, as well as any information we may receive or maintain in the future.

Please note that we do not destroy your Health Information when you terminate your coverage with us. It may be necessary to use and disclose this information for the purposes described above even after our coverage terminates, although policies and procedures will remain in place to protect against inappropriate use and disclosure.

Gramm-Leach-Bliley ("GLB") Privacy Notice

We understand your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of *nonpublic personal information* ("NPI"). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

COLLECTING YOUR INFORMATION

We collect NPI about our customers to provide them with insurance products and services. This may include your name, Social Security number, telephone number, address, date of birth, gender, work/school enrollment history, and health history. We may receive NPI from your completing the following forms:

- Claims forms
- Enrollment forms
- Beneficiary designation/Assignment forms
- Any other forms necessary to effectuate coverage, administer coverage, or administer and pay your claims

We also collect information from others that is necessary for us to properly process a claim, underwrite coverage, or to otherwise complete a transaction requested by a customer, policyholder or contract holder.

SHARING YOUR INFORMATION

We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization such as a policyholder's or contract holder's broker, a third-party administrator, reinsurer, employer, school, or plan sponsor. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

We do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

HEALTH INFORMATION

We will not share any of your protected health information ("PHI") unless allowed by law, and/or you have provided us with the appropriate authorization. Additional information on how we protect your PHI can be found in the Notice of Privacy Practices.

SAFEGUARDING YOUR INFORMATION

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees or authorized individuals who need to know the NPI to provide insurance products or services to you. Our employees are continually trained on how to keep information safe.

ACCESSING YOUR INFORMATION

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our processing costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

CORRECTING YOUR INFORMATION

If you believe the NPI we have about you is incorrect, please write to us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two (2) years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two (2) years.

CONTACTING US

If there are any questions concerning this notice, please feel free to write us at:

Privacy and Security Officer
Commercial Casualty Insurance Company
c/o Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369

In California
c/o Wellfleet Group, LLC
dba Wellfleet Administrators, LLC
PO Box 15369
Springfield, MA 01115-5369

NOTICE OF NON-DISCRIMINATION AND ACCESSIBIILITY REQUIREMENTS

The Company complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Company does not exclude people or treat them worse because of their race, color, national origin, age, disability, or sex.

The Company provides free aids and services to people with disabilities to communicate effectively with us, such as:

1. Qualified sign language interpreters
2. Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose first language is not English when needed to communicate effectively with us, such as:

1. Interpreters
2. information translated into other languages

If you need these services, contact Betsy M. Stevens and John Kelley Civil Rights Coordinators.

If you believe that Commercial Casualty Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Betsy M. Stevens and John Kelley Civil Rights Coordinators,
PO Box 15369
Springfield, MA 01115-5369
(413)-733-4540; (413)-733-4612
Bstevens@wellfleetinsurance.com, or Jkelley@wellfleetinsurance.com.

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance Betsy M. Stevens and John Kelley of Civil Rights Coordinators are available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
800-8681019; 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ADVISORY NOTICE TO POLICYHOLDERS

U.S. TREASURY DEPARTMENT'S OFFICE OF FOREIGN ASSETS CONTROL ("OFAC")

No coverage is provided by this Policyholder Notice nor can it be construed to replace any provisions of your policy. You should read your policy and review your Declarations page for complete information on the coverages you are provided.

This Policyholder Notice provides information concerning possible impact on your insurance coverage due to the directives issued by OFAC and possibly by the U.S. Department of State. **Please read this Policyholder Notice carefully.**

OFAC of the U.S. Department of Treasury administers and enforces economic and trade sanctions policy on Presidential declarations of "National Emergency". OFAC has identified and listed numerous:

- Foreign agents;
- Front organizations;
- Terrorists;
- Terrorist organizations; and
- Narcotics traffickers

as *Specially Designated Nationals* and *Blocked Persons.* This list can be found on the U.S. Department of Treasury's website (www.treas.gov/ofac)

In accordance with OFAC regulations, or any applicable regulation promulgated by the U.S. Department of State, if it is determined that you or another insured, or any person or entity claiming the benefits of this insurance has violated U.S. sanctions law or is identified by OFAC as a *Specially Designated National* or *Blocked Person*, this insurance will be considered a blocked or frozen contract and all provisions of this insurance will be immediately subject to OFAC. When an insurance policy is considered to be such a blocked or frozen contract, neither payments nor premium refunds may be made without authorization from OFAC. Other limitations on the premiums and payments also apply.

Women's Health & Cancer Rights Act

If you have had or are going to have a Mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). If you are receiving Mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient for:

a. Reconstruction of the breast on which the Mastectomy was performed;
b. Reconstruction of the other breast to produce a symmetrical appearance;
c. Prosthesis;
d. Treatment of physical complications from all stages of Mastectomy, including lymphedemas.

Coverage will be subject to the same plan limitations, copays, deductible and coinsurance provisions that currently apply to Mastectomy coverage and will be provided in consultation with you and your attending physician.

LANGUAGE ASSISTANCE PROGRAM

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call (877) 657-5030.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al (877) 657-5030.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請致電：(877) 657-5030.

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi (877) 657-5030.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. (877) 657-5030번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa (877) 657-5030.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру (877) 657-5030.

تنبيه: اذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ (877) 657-5030.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan (877) 657-5030.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le (877) 657-5030.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer (877) 657-5030.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para (877) 657-5030.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero (877) 657-5030.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie (877) 657-5030 an.

注意事項：日本語 **(Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。(877) 657-5030 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد.
(877) 657-5030 تماس بگیرید.

कृपा ध्या द□: य□द आप □**हंद□ (Hindi)** भाषी ह□ तो आपके □लए भाषा सहायता सेवाएं□न:शुल्क उपलब् ह□। कृपा पर काल कर□ (877) 657-5030

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau (877) 657-5030.

ប្រយ័ត្ន: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ**(Khmer)** សេវាកម្មភាសាជំនួយឥតគិតថ្លៃមានសម្រាប់អ្នក។

សូមទូរស័ព្ទមកលេខ (877) 657-5030 ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti (877) 657-5030.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' (877) 657-5030 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac (877) 657-5030

ગુજરાતી (Gujarati) ચુ ના: જો તમે જરાતી બોલતા હો, તો ન:ુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો (877) 657-5030

λληνικά (Greek)ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε (877) 657-5030

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (877) 657-5030

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ(877) 657-5030

ਪੰਜਾਬੀ (Punjabi) ਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ (877) 657-5030

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ,
ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ (877) 657-5030

SUMMARY OF THE LOUISIANA LIFE AND HEALTH

INSURANCE GUARANTY ASSOCIATION ACT AND

NOTICE CONCERNING COVERAGE

LIMITATIONS AND EXCLUSIONS

Residents of Louisiana who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are required by law to be members of LLHIGA. The purpose of LLHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, LLHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through LLHIGA is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Louisiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions.

Coverage is always generally conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

LLHIGA	Department of Insurance
P. O. Box 44126	P. O. Box 94214
Baton Rouge, LA 70804	Baton Rouge, LA 70804-9214

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law (the Law), and is set forth at R.S. 22:2081 et seq. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the law or the rights or obligations of LLHIGA.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a direct non-group life, health or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons may also be protected as well even if they live in another state unless they are afforded coverage by the guaranty association of another state, or other circumstances described under the law are applicable.

(over)

EXCLUSIONS FROM COVERAGE

1. A person who holds a direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to
any of these, or an unallocated annuity contract is not protected by LLHIGA if:

    a. he is eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.);
    b. the insurer was not authorized to do business in this state;
    c. his policy was issued by a profit or nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as is defined in R.S. 22:952(A)(3), or any entity similar to any of these.

2. LLHIGA also does not provide coverage for:

    a. any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
    b. any policy of reinsurance (unless an assumption certificate was issued);
    c. interest rate or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;
    d. dividends, premium refunds, or similar fees or allowances described under the Law;
    e. credits given in connection with the administration of a policy by a group contract holder;
    f. employers', associations' or similar entities' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or underinsured;
    g. unallocated annuity contracts (which give rights to group contract holders, not individuals) except unallocated annuity contracts and defined contribution government plans qualified under section 403(b) of the United States *Internal Revenue Code* (26 U.S.C. 1403(b));
    h. an obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the law;
    i. a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to "Medicare Part C coverage" or "Medicare Part D coverage" and any regulations issued pursuant to those parts;
    j. interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNT OF COVERAGE

1. The Louisiana Life and Health Insurance Guaranty Association Law also limits the amount that LLHIGA is obligated to pay out.

2. The benefits for which LLHIGA may become liable shall in no event exceed the lesser of the following:

    a. LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or an insolvent insurer.
    b. For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance.
    c. For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $500,000 in health insurance benefits, and LLHIGA will pay a maximum of $250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.

3. In no event, regardless of the number of policies or contracts there were with the same company, and no matter how many different types of coverages, LLHIGA shall not be liable to expend more than $500,000 in the aggregate with respect to any one individual.